

ACCULTURATION, PERCEIVED SOCIAL SUPPORT, AND HEALTH-RELATED
QUALITY OF LIFE AS FACTORS IN HEALTH-CARE-SEEKING BEHAVIOR
AMONG AFRICAN-AMERICAN WOMEN

By

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For my father, Ulysses Nathaniel Reid, and my mother,
Margaret Lovings Reid, whose unconditional love and support
have made this achievement possible.

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This study examined acculturation, perceived social support and overall health-related quality of life (as well as physical health and psychological well-being) as factors in health-care-seeking behaviors among African-American women. An assessment battery consisting of the following instruments, was administered to 124 African-American women in the southeastern part of the United States: (1) The African-American Acculturation Scale (AAAS); (2) The family and friends subscale of The Multi-Dimensional Support Scale (M-DSS); (3) The RAND 36-Item Health Survey, version 1.0 (RAND); (4) The Health-Care-Seeking Behavior Questionnaire (HCSBQ); (5) The Marlowe-Crowne Social Desirability Scale,

Short Form [M-C SDS (20)]; and (6) A Demographic Questionnaire. Participants were recruited from churches, colleges, businesses and organizations within various African-American communities.

Controlling for the influence of the social desirability variable with partial correlations, no significant associations were found between any of the independent variables (acculturation, perceived social support, and health-related quality of life) and health-care-seeking behaviors. In addition, results indicated that there were no significant age or income-related differences in levels of acculturation, perceived social support, or overall health-related quality of life (as well as physical health and psychological well-being). Finally, results of a multiple regression analysis suggested that neither acculturation, perceived social support, nor health-related quality of life were significant predictors of health-care-seeking behaviors in African-American women. Analyses indicated, however, that low but significant correlations were found between (1) level of acculturation and psychological well-being and (2) level of social support and psychological well-being.

CHAPTER 1 INTRODUCTION

Health behavior research is indeed an emerging area of interdisciplinary study. As such, promising opportunities for the inclusion of counseling psychologists in health care have been well documented over the past several years (Alcorn, 1991; Klippel & DeJoy, 1984; May, 1977; Alcorn & McPhearson, 1997). Although counseling psychologists have demonstrated a growing interest in health care, some have been hesitant to embrace opportunities in health-care settings due to the more traditional role in educational settings and from reservations regarding the fact that the traditional medical model embraces a disease orientation (Alcorn & McPhearson, 1997).

Over the years, there has been an on-going shift from a more traditional medical (disease) model to a more preventative model of health care. Thus, individuals are encouraged to engage in proactive health behaviors and adopt personal habits that would facilitate better health. As such, interventions made available by counseling psychologists have become increasingly salient to the health

enterprise (Alcorn & McPhearson, 1997). These interventions have primarily focused on (1) identifying barriers to health care and/or utilization of health-care services and (2) finding ways in which to facilitate better health care through improved health-care practices and/or increased utilization of health care services.

Statement of the Problem

In recent years, several lines of research have focused on the important role of individual health behavior in the prevention of illness and premature mortality. Studies have concluded that failure to seek preventive health care or engage in preventive health-care behavior ultimately leads to diminished physical health and/or higher mortality rates (Belloc, 1973; Belloc & Breslow, 1972; Broman, 1993; Ferraro, 1993; Mutchler & Burr, 1991;). Both epidemiological and service use studies have shown significant racial differences in the health status of adult Americans (Ferraro, 1993). On most measures of health, including life expectancy, morbidity, and mortality, African-Americans evidence lower levels of health than their White counterparts.

According to Cummings and Dehart (1995), a report published by the Task Force on Minority Health in 1985 stated that a number of disparities have been identified

between the health status of ethnic groups and Whites in the United States. Of all major causes of death combined - including heart disease, diabetes, cancer and accidents - African Americans showed a 1.5 percent greater likelihood of dying in comparison to Whites. More importantly, African-American females showed more than a 4 to 1 ratio over White females for such deaths.

While health status among African-Americans has improved over the past twenty years or so, the health differential between Whites and African Americans remains quite notable (Cummings & Dehart, 1995). Ironically, the lower health status of African Americans as compared to Whites has not resulted in increased research to understand the health status of African Americans; there has especially been a paucity of such research with African-American women (Ahijevych & Bernhard, 1994).

Some of the limited research that has included African-American women has focused on breast cancer - a disease that is of major concern to both White women and African-American women. This research has shown that while African-American women have lower incidence rates of breast cancer than do White women, African-American women have a more advanced stage at diagnosis and higher mortality in comparison to White women (Lauver, 1994). These differences in stages at

diagnosis and mortality rates have been linked directly to racial differences in health-care-seeking behavior. Other health-related research involving African-American women has included AIDS-related risky sexual behavior (Hines, Snowden, & Graves, 1998; Klonoff & Landrine, 1997), smoking (Landrine & Klonoff, 1997; Landrine & Klonoff, 1996), and hypertension (Landrine & Klonoff, 1996)

Research that focuses on a particular segment or on a particular population is vital in that it can enable researchers to draw conclusions that are appropriate to the specific cultural group under study (Sue, Chun & Gee, 1995). For instance, research is needed to identify those variables that may serve as barriers to health-care-seeking behavior of African-American women. Thus, this study was exploratory in nature and was designed to examine both physical and psychological variables that influence the health-care-seeking behavior of African-American women. Specifically, this project was designed to assess acculturation, perceived social support, and health-related quality of life as factors that influence health-care-seeking behavior among African-American women.

Need for the Study

The impetus for this study came from the literature indicating a need for more in-depth research involving

African-American women and their health-care practices. The current study, therefore, assessed potential psychological factors (i.e., acculturation, perceived social support and psychological well-being) and physical factors (self-reported physical health) in the health-care-seeking behavior of African-American women. The benefits that may be gained from this research are: (1) identification of areas for health psychologists and counseling psychologists to target interventions to facilitate health-care-seeking behavior among African-American women; (2) identification of training for health-care professionals that will improve the success of their health-care outreach programs in African-American communities; and (3) provision of an impetus for more culturally sensitive health-related research with the potential of promoting health and preventing illness among African-American women.

Purpose of the Study

The purpose of this study was to investigate potential psychological and physical factors that are associated with health-care-seeking behaviors among African-American women. Specifically, this study examined (1) the relationship between acculturation and health-care seeking behavior, (2) the relationship between perceived social support and health-care-seeking behavior, (3) the relationship between health-related quality of life and health-care seeking

behavior, (4) the differences in levels of acculturation, perceived social support, and health-related quality of life in association with age and income, and (5) whether acculturation, perceived social support, and health-related quality of life are significant predictors of health-care-seeking behavior.

CHAPTER 2 LITERATURE REVIEW

This literature review focuses on the literature relevant to the variables that were investigated in this study. The variables investigated were health-care-seeking behavior, acculturation, perceived social support, and health-related quality of life.

Health-Care-Seeking Behavior

The literature currently abounds with studies that have focused on health behaviors and factors that influence them. Several of these studies have focused on behaviors such as cancer screening (Kang & Bloom, 1993; Kang, Bloom, & Romano, 1994), smoking cessation (Murry et al., 1995), and exercise (Burk & Kimiecik, 1994). A common thread in most of these studies is that they focus on specific behaviors that, when practiced, result in or facilitate better general health. What follows is a synopsis of some of the ways in which health behavior has been viewed or studied in the past.

Health Behavior Definitions

Because there are no specific or rigid boundaries for the term "health behavior," a specific definition for the term has yet to emerge. However, based on earlier research,

a working definition of health behavior has been established as

those personal attributes such as beliefs, expectations, motives, values, perceptions, and other cognitive elements; personality characteristics, including affective and emotional states and traits; and overt behavior patterns, actions and habits that relate to health maintenance, to health restoration and to health improvement. (Gochman, 1982, p. 169)

According to Gochman (1988), behavior denotes something that one does or refrains from doing. This action is not always conscious or voluntary. Furthermore, health behavior does not encompass clinical improvement or physiological recovery; rather, it includes analyses of specific behaviors which, in turn, have an impact on improvement or recovery. Finally, according to Gochman, this broad definition of health behavior includes not only directly observable, overt actions, but also those mental events and feeling states that can be measured indirectly. A definition such as this recognizes "that these personal attributes are influenced by, and otherwise reflect family structure and processes, peer group and social factors, and societal, institutional, and cultural determinants" (Gochman, 1982, p. 169).

Many theories and models have been developed to explain why some individuals engage in preventive measures and/or other health-seeking behaviors. According to Nemcek (1990), adoption of preventive behavior appears to be influenced by

the degree to which an individual values health, as well as the degree to which that individual expects that the behavior will influence health outcomes.

According to Kasl and Cobb (1966), health behavior can be delineated into three major categories: (1) preventive and protective behavior, (2) illness behavior, and (3) sick-role behavior. Preventive and protective behaviors are further defined as being primary or secondary. Primary preventive and/or protective behaviors are those such as eating well, managing weight, exercising, wearing seat belts, obeying traffic laws, and following safety regulations at work. Secondary preventive behaviors do not prevent conditions from occurring; rather, they minimize the impact of a condition by facilitating its early detection. Health behaviors that fall into this category are those that center around regularly scheduled examinations such as pap smears, breast examinations, or dental exams.

The two remaining health behaviors as defined by Kasl and Cobb (1966) - illness behavior and sick-role behavior - are somewhat similar in nature. Illness behavior comprises those actions taken by individuals who are experiencing signs and symptoms of illness whereas sick-role behavior denotes those actions taken by individuals who already have been classified by themselves or by others as being ill. In

the former case, behaviors can range from actively seeking information and advice from those deemed as having health expertise to passively waiting to see if the symptoms go away. In the latter case, behaviors include actions related to recovery and wellness such as adherence to and/or acceptance of a medically prescribed regimen.

For the purpose of this study, health behavior is more specifically defined as health-care-seeking behavior. While health-care-seeking behavior encompasses facets of all three types of health behaviors outlined by Kasl and Cobb (1966), it primarily focuses on how likely an individual is to seek medical attention to prevent illness or to address and/or to receive follow-up care. As such, the goal of this study is to see what types of variables are associated with African-American women's health-care-seeking behaviors - behaviors that, when practiced regularly and consistently, may facilitate good health.

Throughout the literature, there have been several documentations of determinants of health services utilization as well as other health-related behaviors. In 1991, it was noted that 21% of African-Americans reported having no usual source of medical care. Instead, many African-Americans choose to seek medical care only when their medical symptoms became acute. This source of care is

usually that of an outpatient hospital setting such as a hospital clinic or an emergency room. In these settings, the lack of money or insurance presents less of an obstacle than when seeking services in a physician's office. The downside, however, is that this source of usual care does not allow for continuity of care due to the sporadicity of the visits (National Center for Health Statistics, 1993). As such, this type of medical care is seen as a "Band-Aid:" when the symptoms are alleviated, many African Americans cease to seek continued care (Flack, Amaro, Jenkins, Kunitz, Levy, Mixon & Yu, 1995).

According to Flack, et al., (1995), cultural barriers also significantly affect the rate of utilization of health services among African Americans. For instance, there is often a degree of discomfort or distrust by African Americans of non-minority health-care providers. Part of this discomfort stems from the lack of cultural awareness and/or understanding on the part of the health-care professional. Thus, due to the lack of practicing health-care providers of the same ethnic background, African Americans typically shy away from the medical attention they need. If more efforts were structured around understanding their culture and their lifestyle, African Americans might be more receptive to efforts to improve their health status.

Throughout the literature, several studies have examined health-care utilization patterns in particular. Specifically, studies have examined the relationship between health-care utilization and the following variables: hypertension (Pavlik, Hyman, Vallbona, Toronjo, & Louis, 1997); race (Fichtenbaum, & Gyimah-Brempong, 1997); caregiving for others (Burton, Newsom, Schulz, Hirsch, & German, 1997); alcohol use/frequency of use (Kunz, 1997); and preventive health behaviors (Takemura, Hashimoto, & Gunji, 1997). While most of these studies focus on health-care utilization in terms of number of doctor's visits, or compliance with a medical regime, other studies focus on a broader sense of utilization of service in terms of information-seeking as a major component of a personal health practice repertoire.

In an effort to promote health and prevent disease, individuals must search out new information, as having adequate information is a significant contributor to learning and adopting new health practices. In a study by Rakowski, Assaf, Lefebvre, Lasater, Niknian, and Carleton (1990), 281 adults ranging in age from 18 to 75 were interviewed about a variety of personal health practices. Results of this study indicated that women were more likely than men to seek out information pertaining to health.

Furthermore, an association was found between information seeking and favorable responses to several other health-related practices. Interesting, however, is the fact that using formal health services was the only type of health practice that was not associated with information seeking.

According to documentation by the US Department of Health and Human Services (1992), other factors that can be attributed to differences in health-care utilization between Blacks and Whites in particular are access to care, dissatisfaction with past services and symptom perception. In most cases, studies such as these have resulted in inconsistent findings. However, few studies have actually examined factors associated with health-care-seeking behaviors (i.e., factors that determine whether one is likely to engage in routine visits to a primary care physician or whether one is likely to maintain follow-up visits or be compliant with a prescribed medical regimen once under a physician's care) among non-White populations (Keith & Jones, 1990). The lack of research in this area is especially true for African-American women.

According to Nemcek (1990), several studies have investigated the correlation between the health-belief model and the practice of breast self examination. While the results have been encouraging, several gaps remain in the

findings due to inconsistencies. In addition, subjects in these studies were limited primarily to Caucasian, middle-income, high-school-educated women. According to Nemcek, African-American women were typically not sampled, and studies pertaining to the breast self examination and health beliefs among this particular group were not located.

In their study on preventive health behavior among adults, Rundall and Wheeler (1979) attempted to compare three models - financial constraints, health beliefs, and system barriers - for predicting preventive medical visits. Data for this study were collected by means of a retrospective cross-sectional survey of adults. These adults were questioned about their beliefs regarding susceptibility and severity of four diseases as well as the benefits of professional intervention for preventing these diseases. Findings indicated that susceptibility was the only significant bivariate correlate of preventive visits. Findings also indicated that "having a usual source of care" was the single best predictor of preventive visits. This "usual source of care" might be seen as an indirect measure of barriers to care. In other words, individuals might be less likely to engage in preventive measures if they did not have a health-care facility or a primary care physician who was readily available to them.

An exploration of the existing literature seems to indicate that the majority of previous research on health behaviors, beliefs, and attitudes was conducted using what is known as a "deficit model" approach (Landrine & Klonoff, 1994). Research using a deficit model compares the performance of African Americans and other non-majority groups to Whites without giving consideration to the determinants of this performance (i.e., factors directly associated with the concept in question). In addition, the performance of Whites is often used as the standard or basis for such comparisons. What typically results is a case in which African Americans and other non-majority groups perform lower than their White counterparts. This lower performance is then deemed as being inferior or deficit performance.

The "difference model" approach to research (Oyemade & Rosser, 1980) differs from the deficit model approach in that it is sensitive to and respectful of cultural differences between various ethnic groups. As such, it separately examines factors or variables in target behaviors of each cultural group. Thus, research using a difference model approach focuses on identifying or isolating determinants of differences among African Americans rather than focusing on their deficits relative to Whites.

Because studies in the past that have examined racial differences in health and health-care utilization between Whites and African-Americans have typically done so using a deficit model, the findings usually depict African-Americans as having a significantly lower health-status and a lower level of health-care utilization in comparison to Whites (Blendon, Aiken, Freeman & Corey, 1989; Mutchler & Burr, 1991). Some factors associated with these differences between African Americans and Whites are socioeconomic status, education level, occupation, and access to a physician. In addition, when compared to Whites, African Americans are more likely to come up deficient in areas such as economics (Manuel & Reid, 1982), general health (Travino & Moss, 1984), and life satisfaction (Linn, Hunter, & Perry, 1979).

Because of the aforementioned disadvantages, it is possible to assume that factors such as socioeconomic status, health insurance coverage, perceived health status, and psychological well-being may be more influential in explaining utilization patterns for African Americans than for Whites (Keith and Jones, 1990). According to Fichtenbaum and Gyimah-Brempong (1997) however, even when factors such as these are equalized across race, significant differences in the utilization of health-care services still remain.

When it came to health behaviors such as exercise, nutrition practices, and stress management however, Felton, Parsons, Misener, and Oldaker (1997) found that there were more commonalities than differences between White and Black women once socioeconomic status was taken into consideration.

Keith and Jones (1990) examined determinants of health services utilization among Black and White elderly. Data for this study were taken from the 1975 National Survey of the Aged. This survey, one of the few to include a representative number of African Americans for separate analysis, attempted to describe the social support, employment, assets and general living conditions of 2,143 older Americans. Of this number, only 413 were African American.

Results of the Keith and Jones (1990) study indicated the following: (1) African Americans were more likely to be female, widowed, and have lower educational attainment; (2) Whites were more likely to have participated in the labor force; and (3) Whites had a definite advantage in terms of income and health insurance. It also was determined that racial differences in need for medical care were also evident. Specifically, African Americans did not score as high as Whites on the index of general morale and were more likely to be lonely. In addition, African Americans seemed

to have a more negative outlook on life. They were more likely to rate their health as being poor rather than good or excellent and showed greater evidence of disability in comparison to Whites (31 percent of African Americans versus 13 percent of Whites). Finally, racial differences in utilization behaviors were found as well. It was determined that African Americans were more likely to be hospitalized and to have longer hospital stays than Whites. This was due in part to the fact that African Americans, due to lack of resources and other factors, tend to delay treatment until illness is at a more advanced stage. According to Keith and Jones, there is a need for research that separately examines determinants of health-care utilization for African Americans and Whites (i.e., a difference model approach).

Unlike most studies, one by Lauver (1994) did not find differences in care-seeking behavior based on race. Lauver proposed that a possible explanation for this finding is that the African-American and Caucasian women in this study were similar in terms of education, income, occupation, resources for care, and psychosocial variables.

In a study by Pappas, Queen, Hadden, and Fisher (1993), it was determined that when levels of SES are similar among Blacks and Whites, racial differences in mortality rates are still observed. It was noted that at similar levels of

educational attainment, mortality rates were higher among Black men and women in comparison to their White counterparts. These racial differences were especially noted at the lower end of the SES hierarchy. Thus findings from this research suggest that although ethnic differences in SES are important, other factors are influential in accounting for ethnic differences in morbidity and mortality rates.

Due to (1) the lack of research that has examined health behavior and/or health care-seeking behavior in a cultural context, and (2) the number of discrepancies in research findings that have examined health-related variables across cultures, further studies are needed that give weight to this important factor. This type of cultural sensitivity was the goal of this research.

Acculturation

Acculturation, the extent to which ethnic-cultural minorities participate in the cultural traditions, values, beliefs, assumptions, and practices of the dominant White society, has emerged as a promising, nonracist model for explaining and understanding differences among various ethnic groups (Landrine & Klonoff, 1995). According to the concept of acculturation, one can be identified as acculturated (adopting the practices and beliefs of the

dominant White society), traditional (remaining immersed in one's own cultural traditions), or bicultural (participating in the traditions of one's own culture and those of the dominant White society. Research has shown that while highly traditional ethnic minorities differ significantly from Whites on a number of scales and behaviors, highly acculturated minorities typically do not (Dana, 1993). As such, many ethnic minorities can be understood in terms of degree of acculturation without resorting to a deficit model explanation. Thus, the concept of acculturation has the potential to decrease racist beliefs about ethnic differences and increase the understanding of such differences as a manifestation of culture (Landrine & Klonoff, 1995).

Because acculturation is seen as an essential precursor to the understanding of cultural diversity in human behavior, acculturation scales have been developed for a variety of racial/ethnic groups including, but not limited to, Latino Americans (Cuellar, Harris, & Jasso, 1980) and Native Americans (Hoffman, Dana, & Bolton, 1985). While these scales have existed for various ethnic groups such as those mentioned, an acculturation scale did not exist for African Americans until 1994 (Landrine & Klonoff, 1996). According to Landrine and Klonoff, one reason for this lack

of development of an African-American acculturation scale is that traditionally, psychology as a discipline tended to regard African Americans as a racial group rather than as both a racial group and an ethnic group. As such, African Americans were viewed by traditional psychology and society as persons without a culture. Many researchers in the area of Black Psychology, however, have provided empirical evidence for a distinct African-American culture, which led to the development of the African-American Acculturation Scale (see Landrine & Klonoff, 1994).

Acculturation and Health

Research has found strong relationships between acculturation and stress (Berry & Annis, 1974; Berry, Uichol, & Mok, 1987), hypertension (Dressler, Mata, Chavez, & Viteri, 1987), neuropsychological test performance in normal and HIV-positive individuals (Manly, Miller, Heaton, Byrd, Reilly, Velasquez, Saccuzzo & Grant, 1998), sexual (HIV) risk-taking (Newcomb, Wyatt, Romero, Gloria, Tucker, Wayment, Carmona, Solis & Mitchell-Kernan, 1998) and psychiatric disorders (Burnam, Hough, Karno, Escobar, & Telles, 1987). Such research indicates the importance of studying the cultural context of health behavior. As such, it provides clear information as to how to tailor

interventions to be more effective across ethnic groups (Landrine & Klonoff, 1994).

While there are no known studies to date that have examined the relationship between acculturation and health-care-seeking behaviors as defined by this study, studies do exist that have examined acculturation and general health behavior/health status. Maxwell, Bastani, and Warda (1998) examined the relationship between mammography utilization and acculturation among Korean-American women. In this study, a convenience sample of 229 predominately low-income Korean women were used. Face-to-face interviews were conducted with this sample of women, who ranged in age from 50 to 75 years old. Of this sample, 49% had never had a mammogram, while 24% had received a mammogram within the past twelve months, and 36% had received a mammogram within the past two years. Results indicated that variables positively associated with receiving a mammogram were as follows: having health insurance, having an income greater than \$25,000, having received a recommendation to have a mammogram by a physician, holding positive group norms and greater acculturation. Findings also revealed that fear of finding cancer, time factors, transportation difficulties, embarrassment, and discomfort with the physician were

variables that were negatively associated with receiving a mammogram.

Several studies have examined the relationship between health behavior/health status and acculturation among African Americans in particular. In a study by Hines, Snowden, and Graves (1998), the relationship between acculturation, alcohol consumption, and AIDS-related risky sexual behavior was examined. The participants in this study consisted of 470 African-American women from a national probability sample. Results revealed that there was a significant negative relationship between acculturation and drinking. Specifically, the heaviest drinkers were the least acculturated. Results of the study also indicated that there was a direct relationship between risky sexual behavior and acculturation. In other words, those individuals who were high in acculturation were also high in risky sexual behavior.

Two well-documented studies that have examined acculturation and health-behavior/health status among African Americans have focused on smoking - the single most preventable cause of death (U.S. Department of Health, Education, and Welfare, 1979) and hypertension - one of the most serious health problems among African Americans (Hildreth & Saunders, 1992; Polednak, 1989).

Smoking-related health problems such as cancer, stroke, hypertension, and cardiovascular disease are foremost among the major health problems of African-Americans (Centers for Disease Control, 1989). In addition, these smoking-related health problems are more prevalent among African-Americans than Whites in general (Hildreth & Saunders, 1992) and African-American women in particular (Klonoff, Landrine, & Scott, 1995). As such, a study was conducted by Landrine and Klonoff (1996) that examined the role of African-American acculturation in cigarette smoking among adults. Four hundred and forty-four African-American adults participated in this study.

The sample completed a questionnaire consisting of the African-American Acculturation Scale (AAAS), demographic questions, and a question assessing whether or not the participant smoked. Results indicated that African-American smokers were more traditional (less acculturated) than African-American nonsmokers. Furthermore, it was found that acculturation was a better predictor of smoking than status variables such as income and education level. Results revealed that the prevalence of smoking among traditional African Americans was 33.6% in comparison to the prevalence of smoking among acculturated African Americans, which was 15.3%. According to Klonoff and Landrine, these findings

suggest the need for further exploration of the role of acculturation in African-American health and health-related behavior.

A related study conducted by Landrine and Klonoff (1997) also examined the role of African-American acculturation in cigarette smoking among adults. Five hundred and twenty African-American adults participated in this study. The sample completed the African-American Acculturation Scale along with questions on smoking obtained from the National Health Interview Survey. Results again indicated that smokers scored higher than nonsmokers on the AAAS total score, indicating a more traditional cultural orientation. Specifically, results revealed that smokers had more traditional health beliefs, more strongly endorsed cultural superstitions, had more traditional interracial attitudes (greater distrust of Whites), and were more likely than nonsmokers to prepare and consume traditionally African-American foods.

In a similar study, Landrine and Klonoff (1996) examined the relationship between hypertension and acculturation among African-American adults. Participants consisted of 153 African-American adults who completed a questionnaire consisting of the AAAS, demographic questions, and a question that read "Has your doctor ever told you that

you have high blood pressure?" which was answered yes or no. Results indicated that hypertensives (those who responded yes to the blood pressure question) scored higher than normotensives (those who responded no to the blood pressure question) on the total AAAS in general and two subscales (Traditional African American Childhood Socialization and Foods) in particular. Thus, hypertensives tended to be more traditional and normotensives tended to be more acculturated.

Although several studies have focused on acculturation and health behaviors or health status in general, few, if any have examined acculturation and its relationship to health-care-seeking behaviors as defined in this study. Due to the lack of research in this area, the goal of the present study was to examine acculturation as a factor associated with health-care-seeking behavior. In doing so, this study provided a means for investigating and interpreting the health-care-seeking behavior of African-American women in a culturally sensitive, rather than a racist manner. In addition,

the concept of acculturation provides a rudimentary but parsimonious theoretical framework for predicting the nature and the direction of ethnic differences; without such predictions, empirical findings are interesting, but nonetheless serendipitous and their practical applications subsequently limited. (Landrine & Klonoff, 1994, p. 105)

Perceived Social Support

Social support has been demonstrated to affect a number of different health-related behaviors. There are a variety of different types of social support, which range from more artificial systems (those that are time-limited and not normally a part of one's environment) to natural systems (those such as family, friends, and co-workers who are part of one's typical environment) (see Murray, Johnston, Dolce, Lee, & O'hara, 1995). Because of the varied ways of defining social support and the various types of support, the literature on social supports in health demonstrates a lack of clarity about what the term social support means. Traditionally, it has been used to indicate the different ways in which one is linked to others. Problems occur, however, when comparing conclusions from studies that have used social support in different ways.

Social support has been conceptualized along several dimensions, including existence (designation of the presence or absence of a supportive relationship), network structure (where the support comes from), and type (Depner, Wethington, & Ingersoll-Dayton, 1984). In addition, some studies consider social support in terms of demographic or family-related factors such as marriage/partnership or living arrangements (Eaton, 1978). Finally, according to

Hirsch (1981) and Weiss (1974), it is imperative to know information pertaining to the source of the support as well as the type of support. Information such as this would be helpful in determining whether or not a particular type of social support is indeed significant.

Despite the lack of conceptual clarity, a number of studies in the literature have investigated the relationship between social support and health behaviors. Social support has been positively related to never smoking, exercising, desirable weight, and adequate sleep (Gottlieb & Green, 1984). In addition, it has been associated with smoking cessation (Coppatelli & Orleans, 1985; Murray, Johnston, Dolce, Lee, & O'hara, 1995), decreased alcohol use (Kline, Canter, & Robin, 1987), readiness to make positive dietary changes (Sorensen, Stoddard, & Macario, 1998), exercise (Steptoe, Wardle, Fuller, Holte, Justo, Sanderman, & Wichstrom, 1997), quality of life (Ota & Tanaka, 1997), diabetes mellitus (Ford, Tilley, & McDonald, 1998) and decreased stress (Smith, 1985).

In a study by Milligan, Burke, Beilin, Richards, Dunbar, Spencer, Balde, and Gracey (1997), psychosocial variables associated with various health-related behaviors were examined. Participants in this study included 301 Australian men and 282 Australian women (age 18). Results

indicated that barriers for engaging in desirable levels of physical activity included lack of social support. Lack of family support in particular was perceived as a barrier to smoking cessation.

Schaffer and Lia-Hoagberg (1997) examined the effects of social support on prenatal care and other pregnancy-related health behaviors of low-income women. Data for this study were collected in five metropolitan prenatal clinics serving low-income women. Participants included 101 ethnically diverse, primarily single, low-income pregnant women who were between 28 and 40 weeks of pregnancy. Participants completed the Norbeck Social Support Questionnaire, the Prenatal Health Questionnaire, and the Demographic/Pregnancy Questionnaire. Results indicated that social support provided by the partner correlated positively with adequacy of prenatal care (e.g., visits to the health-care professional), whereas social support from others correlated positively with prenatal health behaviors (e.g., exercise and eating properly).

In a study examining the relationship between social support and breast self-examination (Wagle, Komorita, & Lu, 1997), twenty-two women age 55 and older completed the Norbeck Social Support Questionnaire and two other measures that were used to assess the accuracy and frequency of

breast self-examination. Results indicated that social support was indeed significantly related to the frequency of breast self-examination. However, social support was not significantly related to accuracy of breast self-examination. These findings suggest that women's health may indeed benefit from having supportive relationships.

The role of social support also has been studied in African Americans. Specifically, studies have examined social support in African-American adolescents (Coates, 1985; Cauce, 1986), African-American elderly (Marcus-Bernstein, 1986), low-income African Americans (Ball, 1983), and African Americans who are physically challenged (Belgrave & Walker, 1991). These studies typically reveal a positive relationship between social support and mental and physical health outcomes in African Americans (Belgrave & Lewis, 1994).

In a study by Belgrave and Lewis (1994), the role of social support in compliance and other health-related behaviors was investigated. Subjects consisted of 49 African Americans with sickle cell disease and 78 African Americans with diabetes. Subjects were administered a battery of questionnaires that assessed appointment-keeping behaviors, adherence to health activities, and social support. Results indicate that social support was

significantly associated with appointment-keeping behavior and adherence to health activities in both medical populations.

In research examining the role of social support among African-Americans in general, women were found to have significantly larger and more extended informal social support networks than men (Barker, Morrow, & Mitteness, 1998). Little research has been done, however, to determine the role that social support plays for African-American women related to their health-care behaviors. In response to this lack of research, Kang, Bloom, and Romano (1994) examined the role of social support and social ties in cancer screening among African-American women. Four different measures of social ties were included: marital status, number of relatives and friends, church participation, and participation in other organizations. Results indicated that women with more social ties were more likely to have had a routine mammogram than those with fewer social ties. This was true even after variables such as health status, age, health insurance, and having a primary source of care were controlled for.

Although significant associations were found between social ties and cancer screening, no associations were found between social support and the use of cancer screening.

According to Kang, Bloom and Romano (1994), the social support measures included a small number of items; therefore they may not have captured the qualitative features of supportive social interactions. The authors suggest that functional aspects of social support may be less important than the social ties themselves. Despite the limitations in this study, the findings suggest that African-American women with larger social networks are more likely to receive a mammogram than those with smaller social networks. Thus interventions that make use of social ties may indeed play a significant role in promoting early cancer detection.

According to some researchers, studies have consistently shown that Whites have access to more social support than other ethnic groups such as African Americans and Asians (Jay and D'Augelli, 1991; Koniak, Griffin, Lominska and Brecht, 1993; Williams, 1993). However, as with many other variables, the literature pertaining to perceived social support among African Americans is contradictory. A study by Williams (1993) concluded that African Americans perceive their support as being more adequate than do Whites. On the other hand, Koniak, Griffin, Lominska and Brecht (1993) reported that African Americans, in comparison to Whites, perceived less availability of social support. A third study by

Silverstein and Waite (1993) revealed no significant differences in African Americans' or Whites perceptions of support. As is common, however, research focused on African-American women in particular is lacking in this area.

A search of the literature has shown that there are indeed conflicting results on how social support and/or social ties are associated with health behaviors and the utilization of health-care services. Specifically, social support or social ties has been positively associated (Zapka, Stoddard, Costanza, & Greene, 1989), negatively associated (Romano, Bloom, & Syme, 1991), or not associated at all (Rutledge, 1987) with health behaviors or health-care services utilization. Because of the disparities in the role of social support for African Americans in general and the lack of research on social support and African-American women in particular, further research is needed in this area - especially in the area of social support and health-care-seeking behaviors among African-American women.

Health-Related Quality of Life

Several studies throughout the literature have examined health-related quality of life and its relationship to other health-related variables. Specifically, health-related quality of life has been studied in association with personality type (Yamaoka, Shigehisa, Ogoshi, Haruyama, Watanabe, Hayashi, & Hayashi, 1998), pain and discomfort (Skevington, 1998), aftermath of stroke (Williams, 1998), obesity (Barofsky, Fontaine, & Cheskin, 1997), human immunodeficiency virus (HIV) (Chan & Revicki, 1998), and depression (Leidy, Palmer, Murray, Robb, & Revicki, 1998). As with health behavior and social support, however, there are many discrepancies in terms of how health-related quality of life is defined and/or measured.

It has been noted in the literature that there is often confusing and unclear terminology in regard to the concept of health-related quality of life (Leplege & Hunt, 1998). One problem that exists is that of confounding health-related quality of life with quality of life in general. According to Albert (1998), health-related quality of life measures are typically more highly correlated with health status. In addition, health-related quality of life measures are more sensitive to changes in health than more general quality of life measures. Health-related quality of

life, for purposes of this study, refers to one's overall health-related quality of life, as well as one's physical health and one's psychological well-being.

In a study by Skevington (1998), the impact of pain on quality of life was investigated in 320 healthy participants and participants experiencing a range of various illnesses. The mean age of the participants was 44.9 years. In this study, quality of life was assessed using a multidimensional, multilingual generic profile designed for cross-cultural use in health care. Results indicated that pain and discomfort significantly impacted perceptions of general quality of life as it relates to health.

In a related study, Barofsky, Fontaine, and Cheskin (1997) examined the impact of pain on health-related quality of life in medically obese individuals. As reported by the authors, obesity is a major health concern as it is often associated with increased health risks, chronic pain, decreased functional health status and overall well-being. In this study, 312 individuals seeking medically supervised treatment for weight loss completed a sociodemographic questionnaire and the Medical Outcomes Study Short-Form Health Survey (SF-36). In addition, these individuals underwent a series of clinical evaluations. Participants reported experiencing at least moderate pain in the four

weeks prior to treatment. After controlling for sociodemographic factors, body-mass index and depression, obese participants reporting pain scored significantly lower on all SF-36 domains than those not reporting pain. These findings suggest that pain itself is independently associated with impaired health-related quality of life in almost half of the individuals seeking weight-loss treatment.

According to Congress and Lyons (1992), minority status and/or ethnicity exerts an influence on one's quality of health and perceptions of well-being. In addition, Halpern (1993) suggests that minority status might be a plausible risk factor for poor physical health due to variables typically associated with minority status (e.g., low income and lack of access to medical care). Furthermore, Gove (1984) asserts that the causes of women's morbidity rates are multiple and complex and center around the various role demands women assume. These morbidity rates might be especially high among non-White women considering the fact that minority status alone brings with it increased stressors in the forms of discrimination and prejudice (Halpern, 1993).

Because of the noted differences in health-related quality of life between White women and African-American

women, this study examined whether health-care-seeking behavior is associated with health-related quality of life among African-American women. Specifically, this study examined overall health-related quality of life and how it relates to health-care-seeking behavior. In addition, this study examined two specific components of health-related quality of life (physical health and psychological well-being) and their relationship to health-care-seeking behavior among African-American women.

CHAPTER 3 METHODOLOGY

This chapter presents the following information:
operational definitions of the variables in the study,
hypotheses and research questions, subjects, instruments,
and procedure.

Operational Definitions of the Variables

Acculturation is defined in the literature as the degree to which ethnic and/or cultural minorities participate in the cultural traditions, values, beliefs, and practices of their own culture versus those of the dominant or White society (Landrine and Klonoff, 1996). In the present study, acculturation for African-American women is operationally defined as the score on the African-American Acculturation Scale (AAAS) (Appendix C). The African-American Acculturation Scale is a continuous scale with lower scores indicating more acculturation and higher scores indicating more traditional beliefs and behaviors. According to the authors, it is not possible to know what scores in the midrange indicate.

Social Support is defined in the present study as the degree to which one feels support from significant people in her life. Social support is operationally defined as the score on the Family and Friends subscale on the Multi-Dimensional Support Scale (M-DSS) (Appendix D). The M-DSS measures perceived availability of social support and satisfaction with social support from three potential sources - family and friends, peer group, and supervisors.

Health-related quality of life is defined in the present study as one's overall perception of the quality of her life. In addition, particular attention is given to one's perception of her physical health and her psychological well-being - two components of overall health-related quality of life. As such, health-related quality of life is operationally defined in the following manners:

(1) Health-related quality of life is operationally defined as the total score on the RAND 36-Item Health Survey (Version 1.0); (2) health-related quality of life is operationally defined as the score on the Physical Functioning (physical health) subscale of the RAND 36-Item Health Survey (Version 1.0); and (3) health-related quality of life is operationally defined as the score on the Emotional Well-Being (psychological well-being) subscale of the RAND 36-Item Health Survey (Version 1.0) (Appendix E).

Health-care-seeking behavior is defined in the present study as the degree to which one actively engages in health-care behavior, actively seeks out health-care services and/or maintains follow-up care once under a health-provider's care. Health-care-seeking behavior is operationally defined as the score on the Health-care-seeking Behavior Questionnaire (HCSBQ) (Appendix F).

Hypotheses and Research Questions

This study tested the following hypotheses:

- (1) Degree of acculturation (AC) is significantly associated with health-care-seeking behaviors (HCSB) such that the greater the degree of acculturation, the greater the level of engagement in health-care-seeking behaviors.
- (2) Perceived social support (SS) is significantly associated with health-care-seeking behaviors (HCSB) such that the greater the level of perceived social support, the greater the level of engagement in health-care-seeking behaviors.
- (3) Overall health-related quality of life (HRQL), as well as physical health (PHY) and psychological well-being (PSYCH) - two components of health-related quality of life - are significantly associated with health-care-seeking behaviors (HCSB) such that the greater the level of overall health-related quality of life, as well as physical health

and psychological well-being, the greater the level of engagement in health-care-seeking behaviors.

The possible effects of age (AGE) and total household income (INCOME) on the major variables of study were addressed in the following research questions:

- (1) Is there a significant difference in level of acculturation (AC) in association with age (AGE) or total household income (INCOME)?
- (2) Is there a significant difference in level of perceived social support (SS) and level of overall health-related quality of life (HRQL) (as well as physical health (PHYS) and psychological well-being (PSYCH)) in association with age (AGE) or total household income (INCOME)?
- (3) Is there a significant difference in level of health-care-seeking behaviors (HCSB) in association with age (AGE) or total household income (INCOME)?

The possible association between level of acculturation, level of social support, and level of health-related quality of life (overall health-related quality of life, as well as physical health and psychological well-being) and health-care-seeking behavior was examined in the following research question:

- (4) Do acculturation (AC), perceived social support (SS), or health-related quality of life (overall (HRQL), as well as

physical health (PHYS) and psychological well-being (PSYCH)) predict health-care-seeking behaviors (HCSB)?

Participants

Participants in this study consisted of 124 African-American women (age 21 and older) recruited from various groups and organizations (e.g., churches, community organizations, and community health centers) in two cities in Georgia that were easily accessible to the researcher involved. Both of these cities have high concentrations of African-American women of varying socioeconomic status. African-American women from the community were used for this project, as opposed to college students, to increase the likelihood that the results would be generalizable to the majority of African-American women. Participants in this study were paid volunteers who received \$10 each for their participation.

The demographic characteristics of the participants in this study are shown in table 3.1. Twenty-three participants were between the ages of 21 and 30 (18.5%), 30 were between the ages of 31 and 40 (24.3%), 37 were between the ages of 41 and 50 (29.8%), 16 were between the ages of 51 and 60 (12.9%), and 18 were age 61 or older (14.5%). Approximately seventy-four percent (74.2%) of the participants reported full-time paid employment ($n = 92$), 11.3% reported part-time paid employment ($n = 14$), and 14.5%

Table 3.1

Summary of Demographic Data

Variable	Frequency	Percentage
Age of Participant		
21 - 30	23	18.5
31 - 40	30	24.3
41 - 50	37	29.8
51 - 60	16	12.9
≥ 61	18	14.5
Paid Employment Status		
Full Time	92	74.2
Part Time	14	11.3
None	18	14.5
Relationship Status		
Single	26	21.1
Partnered	7	5.6
Married	54	43.5
Legally Separated	6	4.8
Legally Divorced	17	13.7
Widowed	14	11.3
Current Total Household Income		
< \$15,000	27	21.8
\$15,001 - \$30,000	31	25.0
\$30,001 - \$45,000	28	22.6
> \$45,000	38	30.6

reported no paid employment ($\underline{n} = 18$). Twenty-six (26) of the participants were single (21.1%), 7 were partnered (5.6%), 54 were married (43.5%), 6 were legally separated (4.8%), 17 were legally divorced (13.7%), and 14 were

widowed (11.3%). In terms of their total household income, 27 participants had incomes of \$15,000 or less (21.8%), 31 had incomes between \$15,001 and \$30,000 (25.0%), 28 had incomes ranging between \$30,001 and \$45,000 (22.6%), and 38 had incomes greater than \$45,000 (30.6%).

Instruments

The Health Behavior Assessment Battery (HBAB) used in this study included the following instruments:

1. Demographic Questionnaire (DQ) (Appendix B)

The Demographic Questionnaire was used to obtain the following information on each participant: age, paid employment status, relationship status, and total household income.

2. African-American Acculturation Scale (AAAS; Landrine & Klonoff, 1994) (Appendix C)

The African-American Acculturation Scale was used to assess degree of acculturation among African-American women. The AAAS is a 74-item scale consisting of eight subscales which are: (1) Preference for African-American Things (e.g., "I feel more comfortable around Blacks than around Whites."); (2) Traditional Family Practices and Values (e.g., "When I was young, my cousin, aunt, grandmother, or other relative lived with me and my family for a while."); (3) Traditional Health Beliefs, Practices, and Folk

Disorders (e.g., "I was taught that you should not take a bath and then go outside."); (4) Traditional Socialization (e.g., "I went to a mostly Black elementary school."); (5) Traditional Food and Food Practices (e.g., "I save grease from cooking to use it again."); (6) Religious Beliefs and Practices (e.g., "The church is the heart of the Black community."); (7) Interracial Attitudes (e.g., "IQ tests were set up purposefully to discriminate against Black people."); and (8) Superstitions (e.g., "I eat black-eyed peas on New Year's Eve.").

The eight theoretically defined subscales of the AAAS, as well as the total AAAS score, have group differences and concurrent validity. The subscales also have high internal consistency reliability, ranging from .71 to .90. The scale as a whole has high split-half reliability ($r=.93$) (Landrine & Klonoff, 1995).

Items on the scale are rated on a 1-7 scale with 1 = "I totally disagree - Not true at all" and 7 = "I strongly agree - Absolutely true." All eight subscales were used for this study; thus, a total sum score was calculated across each of the eight subscales for each participant's score. Participants' scores ranged from a low of 247 to a high of 464 out of a possible score of 518. The sample mean score was 356.19 and the standard deviation was 44.77. According

to Landrine and Klonoff's (1996) validation study, the mean and standard deviation as reported for Blacks is 343.01 and 60.76 respectively.

According to Landrine and Klonoff (1996), very high scores on the AAAS indicate that a person is highly traditional, whereas very low scores indicate that a person is highly acculturated. Because the AAAS only measures degrees of immersion in the African-American culture, comparisons can be made only between the highly acculturated and the highly traditional. This particular scale cannot address biculturalism, multiculturalism, or the meaning of midrange scores on the scale (Landrine and Klonoff, 1996). In order for this to occur, scores on the AAAS would have to be compared to scores on an instrument that measured European American culture. Landrine and Klonoff believe that those individuals who scored equally high on both a European acculturation scale as well as the AAAS could then be classified as bicultural. Those who scored low on both scales would be classified more or less as marginal.

3. The Multi-Dimensional Support Scale (M-DSS; Winefield, Winefield, & Tiggemann, 1992) (Appendix D)

The Family and Friends subscale of the Multi-Dimensional Support Scale was used to assess level of social support. The M-DSS measures perceived availability of

social support and satisfaction with social support from three potential sources - family and friends (or other confidants and/or attachment figures), peer group (or those who are on a similar level or facing the same challenges as the respondent), and experts (or those who have some official role over the respondent such as a supervisor).

The M-DSS is described as a flexible instrument as it can be adapted for use with various populations. Thus, when using this scale, it is imperative that potential sources of support be selected on the basis of the recipient group being studied (Winefield, Winefield, and Tiggemann, 1992). The Family and Friends subscale of the M-DSS was chosen for this particular study because the participants were volunteers from the general population. As such, not all of them would be in a situation where they had either a peer group or a person in authority over them (such as at school or at work).

The M-DSS as a whole is a 38-item scale consisting of 19 two-part core questions. The Family and Friends subscale consists of 7 two-part questions. The first part of each question is answered on a scale of 1 to 4 with 1 = Never, 2 = Sometimes, 3 = Often, and 4 = Usually/Always (e.g., "Think of your family and close friends, especially the 2-3 who are most important to you. How often did they really listen to

you when you talked to them about your concerns or problems?"). The second part of each question is answered by choosing one of the following three choices: "more often"; "less often"; or "it was just about right" (e.g., "And you would have liked them to do this"). In scoring, "more often" = 1, "less often" = 2, and "it was just about right" = 3. A total score is obtained for each participant by adding together the scored responses from each two-part question. Higher scores on the M-DSS indicate higher levels of perceived social support.

The M-DSS is reported to be both sensitive and reliable. Internal reliability coefficient alphas range from .80 to .91. Subscale scores have been found to correlate significantly with affect measures. While there are currently no normative data available, some norms are in preparation. The sample mean of the Family and Friends subscale was 36.76 and the standard deviation was 7.92. Sample scores ranged from a low of 19 to a high of 49 out of a possible 49.

4. The RAND 36-Item Health Survey 1.0 (RAND; Ware, Jr. & Sherbourne, (1992) (Appendix E)

The RAND 36-Item Health Survey 1.0 was used to measure overall level of health-related quality of life (as well as physical health and psychological well-being - two separate

components of overall health-related quality of life). The RAND is a 36-item self-report inventory that assesses eight health concepts that often are used to determine one's health-related quality of life. The eight concepts or subscales included in this scale are as follows: physical functioning, bodily pain, role limitations due to physical health problems, role limitations due to personal or emotional problems, emotional well-being, social functioning, energy/fatigue, and general health perceptions.

The RAND utilizes Likert-type scales for scoring purposes with responses ranging from a score of 0 to a score of 100. A sample item from the RAND reads "Compared to one year ago, how would you rate your health in general now?". This particular question is scored on a scale of 1 to 5 where 1 = 100, 2 = 75, 3 = 50, 4 = 25, and 5 = 0. Alpha reliabilities for the subscales of the RAND range from .78 to .93. For purposes of this research, a mean score was averaged across all eight subscales for an overall health-related quality of life score. No normative data was found for this scale. The sample mean for the overall health-related quality of life scale was 78.92 with a standard deviation of 11.60.

In addition to the overall health-related quality of life score, two separate scores were obtained from two of

the eight subscales: Physical Functioning and Emotional Well-being. The Physical Functioning subscale was used to look at physical health - a component of health-related quality of life. The Physical Functioning subscale is an indirect measure of physical health in that it measures one's perception of limitations in various physical roles or functions as a result of her health. The assumption is that those who are in better physical health will experience fewer physical limitations as a result of their health. In addition, the Emotional Well-being subscale was used to examine level of psychological well-being - also a component of health-related quality of life. Due to the various role demands on African-American women and the physical and psychological stress that results from these demands, it was deemed that the physical functioning and emotional well-being subscales would be of particular interest in terms of understanding more fully respondents' perception of their health-related quality of life.

The alpha reliability for the Physical Functioning subscale (physical health) is .93, and the alpha reliability for the Emotional Well-Being subscale is .90. The mean and standard deviation for the Physical Functioning subscale as reported in the Medical Outcomes Study are 70.61 and 27.42 respectively. Likewise, the mean and standard deviation for

the Emotional Well-Being subscale as reported from the same study are 70.38 and 21.97 respectively. The sample mean and standard deviation for the Physical Functioning subscale is 84.96 and 18.25 respectively. The sample mean and standard deviation for the Emotional Well-Being subscale is 78.32 and 13.05 respectively. Higher scores on the RAND reflect better or more positive perceptions of health-related quality of life.

5. The Health-Care-Seeking Behavior Questionnaire (HCSBQ),
(Appendix F)

The Health-Care-Seeking Behavior Questionnaire is a six-item scale that was developed by the researcher to assess health-care-seeking behaviors among African-American women. Using a five-point Likert-type scale where 1 = very likely and 5 = not likely at all, participants reported how likely they are to engage in health-care-seeking behaviors such as visiting the doctor or other health-care provider for a routine check-up or visiting the doctor or health-care provider when they feel ill. A sample item is "How likely are you to go to a primary health-care provider for a yearly physical check-up?" The items are specifically geared toward visits to a primary care provider for routine visits and preventive health-care.

Internal consistency reliability yielded a Cronbach Coefficient Alpha of 0.76. The participants' scores ranged from a high of 4.33 to a low of 1. The lower a participant's score, the more engaged she was in health-care-seeking behaviors. The sample mean for the HCSBQ was 1.82 and the standard deviation was 0.73.

The HCSBQ originally started out as a ten-item scale. However, a factor analysis of the HCSBQ indicated that there were three separate factors within this questionnaire. Questions 1, 2, 3, 4, 5, and 8 loaded onto factor one and seemed to specifically measure health-care seeking behaviors as defined by this study. Thus, only these items (i.e., factor one items) were used as the final Health-Care-Seeking Behavior Questionnaire (HCSBQ). The mean ratings of these items by each participant was the HCSB score for that participant.

Questions 6 and 7, which loaded onto factor two, seemed to measure more specifically the availability of services, or the degree to which a participant thought medical services were available to her. Questions 9 and 10 loaded onto factor three, which seemed to measure compliance with medication. In other words, it measured whether or not participants were likely to get prescriptions filled and

whether or not they were likely to take all of their prescribed medication.

6. The Marlowe-Crowne Social Desirability Scale, short-form, (M-C SDS [20]; Marlowe & Crowne, 1960)
(Appendix G)

The Marlowe-Crowne Social Desirability Scale was used to measure the amount of variance in the data due to the participants' desire to respond to questions in a culturally appropriate manner. The short version of the Marlowe-Crowne (20 items) is based on the original 33-item instrument. The scale consists of items that are culturally supported but are unlikely to occur. A sample item reads "I am always willing to admit it when I make a mistake." The scale is scored based on the number of "true" or "false" responses to each question. Sample scores ranged from a low of 0 to a high of 20 out of a possible 20. The sample mean was 12.52, and the sample standard deviation was 4.27. The higher a respondent's score, the more likely she was responding in a socially desirable manner.

The Kuder-Richardson formula 20 (K-R 20) reliability coefficients for the 20-item instrument (.78 for university males and .83 for university females) are similar to the K-R 20 reliability for the original 33-item inventory (.83 for university males and .87 for university females). Pearson

product-moment correlations between the 20-item scale and the 33-item instrument were as high as .98, indicating adequate construct validity for the shorter version (Fraboni & Cooper, 1989; Strahan & Gerbasi, 1972). Participant responses on the M-C 20 indicated whether or not the responses to the Health Behavior Assessment Battery were likely to be valid.

A debriefing form describing the nature and purpose of the study was read and signed by all participants at the conclusion of the study (see Appendix H).

Procedure

This research involved three phases: (1) training of research assistants, (2) recruitment of participants, and (3) collection of data.

Phase I: Training of Research Assistants

Phase one of the research consisted of training three African-American female research assistants to assist in the group administration of the Health Behavior Assessment Battery (HBAB). Three adult women from the African-American communities sampled were trained as research assistants in this study. This training was conducted by the principle investigator and lasted approximately one hour. During the training session, each research assistant was shown how to administer the HBAB using a culturally sensitive approach.

Specifically, each research assistant was given a set of verbal instructions to use with the participants in each group session. These verbal instructions were as follows:

Hello, my name is _____. You have verbally agreed to participate in a study that is designed to examine health problems that are often experienced by African-American women and how African-American women cope with these health problems. Before we begin, I would like for you to read and sign the consent form which will now be passed out to you. If you need help reading the form, I will be happy to assist you. There are two copies of the consent form - one for you to keep and one to be returned to me. These forms will be kept separate from the questionnaires you will complete later.

This study will involve completing a series of health-related questionnaires. There are seven questionnaires in all. Each questionnaire has a separate set of instructions at the beginning, so please be sure to read all instructions before starting the questionnaire. You should complete the questionnaires in the order that they are given to you. If you need assistance reading the questionnaires, I will be available to assist you. Please do not put your name on any of the questionnaires.

Please be sure to answer all items to the best of your ability. It usually takes 45 minutes to an hour to complete the questionnaires; however, you may take as much time as you need. Once you have finished your packet of questionnaires, you are to paper clip them together as you found them and place them in the "Completed Questionnaires" box located in the front of the room. You are to then read (or have read to you) a debriefing form, which you will sign, stating that you are aware of the purpose of this study. Should you want group results of this study, you will need to complete your name and address on the "Request for Results" form. You will receive \$10.00 for your participation in this study after you have turned in your questionnaires. You will have completed this study once you have completed all of the questionnaires and signed all appropriate forms. Are there any questions? If not, you may begin.

The research assistants also were shown how to (1) address questions pertaining to the HBAB in the event that someone could not read and/or understand a particular question, (2) collect the completed HBAB, (3) debrief the participants, and (4) collect the "request for results" sheets. Finally, each research assistant was instructed as to how to compensate each participant for her participation. After the training was completed, each research assistant conducted a "mock" session with the principal investigator to confirm that she understood how to conduct the group sessions.

Phase 2: Recruitment of Participants

Participants for this study were solicited from the community at large as well as community churches and other community organizations/centers that have high concentrations of African-American women. The recruitment phase consisted of three separate methods or strategies: (1) Newspaper announcement; (2) flyers; and (3) personal appeals.

Method 1:

Participants from the community at large were recruited via a newspaper announcement about the study. In the announcement, African-American women 21 years of age or older were invited to call the principal investigator or a

research assistant in order to sign up for one of four group sessions, using their initials only. Initials were used in order to protect anonymity. Respondents could call at any time to sign up for a group session. Group session times were set according to times thought to be convenient for most people.

Approximately 70 women responded via phone to the newspaper announcement. Verbal instructions were given to the respondents regarding the date, time, and location of the study. In addition, they were told that the study consisted of completing a packet of questionnaires about African-American women and health that would take approximately 45 minutes to an hour to complete. Finally, respondents were told that they would receive \$10.00 compensation for their participation in the study.

Fifty-six women of the 70 who responded via phone actually showed to participate in the study (80%). A total of four group sessions were conducted for participants who responded via phone to the newspaper ad. All group sessions were conducted at a community church.

Method 2:

Participants also were recruited from churches and other community organizations via flyers about the study. Flyers were posted in places heavily frequented by African-

American women, such as a community health agency, a local school in an African-American community, an African-American managed business, a two-year community college, and an African-American church. Flyers announced that African-American women 21 years of age or older were invited to call the principal investigator or a research assistant in order to sign up for one of four group sessions, using their initials only. Respondents could call at any time. Again, group session times were set according to times thought to be convenient for most people.

Several women responded to the flyers regarding the study - both by phone and in person when the principal investigator or a research assistant was available. Verbal instructions regarding the date, time, and location of the study were given to those who responded by phone. To those responding in person, a reminder slip was given to them that contained information regarding date, place, and time. All respondents were told that the study consisted of completing a packet of questionnaires about African-American women and health. In addition, they were told that the study would take approximately 45 minutes to an hour to complete. Finally, respondents were told that they would receive \$10.00 compensation for their participation in this study.

While the flyer initially stated that four group sessions would be held, a total of 6 group sessions were held in order to accommodate those who were willing to participate but could not attend the pre-determined group sessions. Group sessions were conducted as follows: Two group sessions were conducted at a community health agency, one at a local business, one at a local school, one at a local community college, and one at a local church. A total of 60 African-American women participated in these 6 group sessions.

Method 3:

In addition to a newspaper ad and flyers about the study, participants also were recruited via personal appeals at churches by the principal investigator. In the personal appeal, potential participants were asked to participate in a study on African-American women and health. They were told that the study would involve completing a set of questionnaires that would take approximately 45 minutes to an hour to complete. In addition, they were told that participants would receive \$10.00 compensation for their participation in this study.

Participants who were recruited via personal appeals signed up for one of two group sessions. Both of these times were selected according to normal meeting times for

the church members. Participants signed up using their initials only to protect their anonymity. In addition, the place for both group sessions was indicated on the sign-up sheet so that all participants would know where as well as when to report to participate in this research project. However, each person who signed up to participate in the study was given a reminder sheet indicating the date, time, and place of the group sessions. A total of 30 African-American women participated in these two group sessions.

Phase 3: Data Collection

A total of twelve group sessions were conducted in this study. In all twelve group administration sessions, participants completed the Health Behavior Assessment Battery (HBAB). All instruments in the HBAB, with the exception of the Demographic Questionnaire, were placed in random order within and across group settings in order to control for any order effects on the results. The Demographic Questionnaire was placed last in each packet in case any participant found the information requested too personal, thereby influencing her approach to the study as a whole.

Before receiving the HBAB, participants in each group were told the purpose of the study by either the principal investigator or a research assistant. Specifically, they

were told that the purpose of this study was to examine health problems African-American women often experience and how African-American women cope with these problems. Individuals who agreed to participate in the study then were asked to read (or have read to them) and sign an informed consent form that was collected by the research assistant. Only those individuals who signed an informed consent form were allowed to participate in the actual study. All individuals who showed up for the study chose to participate. Verbal instructions specifying the procedures for data collection were stated previously in the section labeled "Phase 2." Only one participant had difficulty reading the questionnaires and therefore required verbal administration of the HBAB.

Participants were given \$10 compensation for their time and participation. These incentives were especially needed to recruit African-American participants, given their well-documented reluctance to participate in research. The compensation was given immediately after the participants turned in the HBAB and signed the debriefing form.

A debriefing form describing the nature and purpose of the study was read by each individual and signed by all participants at the conclusion of the study. Again, in the case where the participant could not read, the form was read

to her by a research assistant. Prior to starting, participants were told that they could request a report containing a summary of the results from the study and that this summary, if requested, would be mailed to them. In order to facilitate action on this request, participants were given the opportunity to completed a "Request for Results" form on which they placed their name and address. These forms were given to each participant when she placed her completed HBAB in the "Completed Questionnaire" box. Fourteen participants requested results of the study.

Participants took approximately 20 to 50 minutes to complete the HBAB. Participation in this study was voluntary; as such, participants could withdraw their consent at any time without prejudice. No one opted to withdraw. All data collection sessions occurred within a four-week period.

CHAPTER 4

RESULTS

The descriptive data, hypotheses and research questions of interest in this study are discussed in this chapter. The results are delineated in several parts. First, descriptive data on all major variables are reported. Second, the results of a preliminary Pearson correlational analysis to assess relationships among the measures of the dependent variable in the hypotheses and scores on the Marlowe-Crowne Social Desirability Scale are reported. Third, results of the correlational analyses to test the hypotheses are reported. Finally, the statistical analyses used to address the research questions are examined.

Descriptive Data on all Major Variables

Table 4.1 presents the descriptive statistics on all major variables for the total sample. Normative data on the major variables in this study are not available.

Results from the Preliminary Pearson Correlational Analysis

A preliminary Pearson correlational analysis was performed to determine if there was an association between scores on the Marlowe-Crowne Social Desirability Scale (M-C

Table 4.1

Descriptive Statistics on All Major Research Variables

	N	Sample Mean	Sample Std Dev	Sample Min	Sample Max
AC	124	356.19	44.77	247.00	464.00
SS	124	90.60	17.24	50.00	133.00
HRQL	124	78.92	11.60	46.25	100.00
PSYCH	124	78.32	13.05	44.00	100.00
PHYS	124	84.96	18.25	30.00	100.00
HCSB	124	1.67	0.55	1.00	4.00

Notes: AC = Acculturation
 SS = Perceived Social Support
 HRQL = Health-Related Quality of Life
 PSYCH = Psychological Well-Being
 PHYS = Physical Health
 HCSB = Health-Care Seeking Behaviors

SDS) and scores on the major variables of study:

(1) acculturation (AC), (2) perceived social support (SS), (3) overall health-related quality of life (HRQL), as well as physical health (PHYS) and psychological well-being (PSYCH), and (4) health-care-seeking behaviors (HCSB).

Results indicated that social desirability (SD) as measured by the M-C SDS was significantly associated with three of the major variables in the study - the psychological well-being (PSYCH) component of health-related quality of life (HRQL) as measured by the RAND 36 $r = .23$, $p \leq .01$), the physical health (PHYS) component of health-

related quality of life as measured by the RAND 36 $r = -.20$, $p \leq .02$), and health-care seeking behaviors (HCSB) as measured by the HCSBQ $r = -.20$ $p \leq .03$). Consequently, the analyses used to test hypotheses 1, 2, and 3 controlled for the influence of social desirability. The Pearson correlation coefficients for correlations between the Marlowe-Crowne Social Desirability Scale scores and the scores on the major variables of the study are summarized in Table 4.2.

Table 4.2

Pearson Correlation Coefficients for the Marlowe-Crowne Social Desirability Scale (SDS) Scores and Measures of Acculturation (AC), Perceived Social Support (SS), Health-Related Quality of Life (HRQL, PSYCH, and PHYS), and Health-care-seeking Behavior (HCSB)

	SDS	AC	SS	HRQL	PSYCH	PHYS	HCSB
SDS	-	-0.079	0.080	-0.117	0.231**	-0.202*	-0.201*

Note: * $p < .05$, ** $p < .01$

Results from the Analysis to test Hypotheses 1,2, and 3

This study examined the following three hypotheses:

- (1) Degree of acculturation (AC) is significantly associated with health-care-seeking behaviors (HCSB) such that the greater the degree of acculturation, the greater the level of engagement in health-care-seeking behaviors;

(2) Perceived social support (SS) is significantly associated with health-care-seeking behaviors (HCSB) such that the greater the level of perceived social support, the greater the level of engagement in health-care-seeking behaviors; and

(3) Overall health-related quality of life (HRQL), as well as physical health (PHYS) and psychological well-being (PSYCH), is significantly associated with health-care-seeking behaviors (HCSB) such that the greater the level of overall health-related quality of life, (as well as physical health and psychological well-being), the greater the level of engagement in health-care-seeking behaviors.

To test hypotheses one, two and three, a partial correlation analysis was performed. A partial correlation was used in order to control for the influence of social desirability as it was found to be significantly correlated with three of the major variables in the study. Results for hypothesis one indicated that there was no significant relationship between level of acculturation (AC) and level of engagement in health-care-seeking behaviors (HCSB). Thus, hypothesis one, which stated that higher levels of acculturation would be significantly associated with higher levels of engagement in health-care-seeking behaviors, was not supported.

No significant correlation was found between level of perceived social support and level of engagement in health-care-seeking behaviors ($r = -.03$, $p \leq .73$). Thus, hypothesis two, which stated that higher levels of perceived social support would be significantly associated with higher levels of engagement in health-care-seeking behaviors, was not supported.

Results of the partial correlation analysis to test hypothesis three also revealed no significant correlation between overall health-related quality of life and health-care-seeking behaviors ($r = -.06$, $p \leq .48$), physical health and health-care-seeking behaviors ($r = .02$, $p \leq .83$), or psychological well-being and health-care-seeking behaviors ($r = -.04$, $p \leq .633$). Thus, hypothesis three, which stated that higher levels of overall health-related quality of life, (as well as physical health and psychological well-being), would be significantly associated with higher levels of engagement in health-care-seeking behaviors, was not supported.

Additional results from the partial correlation analysis revealed a low but significant negative correlation between level of acculturation and psychological well-being ($r = -.24$, $p \leq .007$). Lower scores on the African-American Acculturation Scale indicate higher levels of acculturation,

whereas higher scores on the Emotional Well-Being subscale of the RAND 36 suggest higher levels of psychological well-being. Thus it appears that African-American women who are more acculturated experience higher levels of psychological well-being.

Finally, results from the partial correlation analysis suggested that there was a low but significant positive correlation between perceived social support and psychological well-being $r = .19, p \leq .04$). This suggests that African-American women who have social support systems also tend to experience higher levels of psychological well-being. The partial correlation coefficients from the partial correlation analysis performed to test hypotheses one, two, and three are presented in table 4.3

Results from the Analyses to test Research Questions 1,2,3 & 4

Research question 1 asked whether there is a significant difference in level of acculturation (AC) in association with age (AGE) or total household income (INCOME). An Analysis of Variance (ANOVA) was used to examine this research question. The dependent variable was acculturation. The independent variables were AGE, INCOME, and AGE x INCOME. Results of the ANOVA indicated that there were no significant differences in acculturation in association with age, income, or the age by income interaction [$F(1, 19) = 1.13, p = .34$].

Research Question 2 asked whether there is a significant difference in level of perceived social support and level of overall health-related quality of life (HRQL), as well as physical health (PHYS) and psychological well-being (PSYCH), in association with age (AGE), total household income (INCOME), and age (AGE) x total household income (INCOME). Two separate MANCOVAs were used to examine this research question. Social desirability (SD) was entered as a covariate to control for its influence as it was significantly correlated with both PSYCH and PHYS.

In the first MANCOVA, the dependent variables were physical health, psychological well-being, and perceived social support. The independent variables were AGE, INCOME, and AGE x INCOME. Results of the MANCOVA showed that there were no significant main effects for age [$F(12, 268) = 1.43, p = .15$] or income [$F(9, 246) = 1.68, p = .09$]. Similarly, there was no significant interaction effect for age x income [$F(36, 299) = 1.42, p = .07$]. These findings suggest that there are no significant differences in perceived social support, physical health, or psychological well-being in association with age, income, or the age by income interaction.

In the second MANCOVA used to examine research question two, the dependent variables were overall health-related

quality of life (HRQL) and perceived social support (SS). The independent variables were AGE, INCOME, and AGE x INCOME. Results revealed that there was no significant main effect for age [$F(8, 204) = .94, p = .49$] nor a significant interaction effect for age x income [$F(24, 204) = 1.49, p = .07$]. There was, however, a significant main effect for income [$F(6, 204) = 2.21, p = .04$]. Only the ANCOVA with overall health-related quality of life was significant [$F(6, 204) = 3.00, p = .03$]. In this ANCOVA, income was the only significant independent variable ($p \leq .03$). Follow-up Tukey's analysis indicated no differences in overall health-related quality of life for African-American women based on income.

Research question 3 asked whether there is a significant difference in level of health-care-seeking behaviors (HCSB) in association with age, total household income, or the age by income interaction. An Analysis of Covariance (ANCOVA) was used to examine this research question. The dependent variable was health-care-seeking behaviors (HCSB). The independent variables were AGE, INCOME, and AGE x INCOME. Additionally, social desirability (SD) was entered as a covariate to control for the influence of this variable as it was significantly correlated with the

health-care-seeking behavior variable. Results of the ANCOVA were not significant [$F(1, 20) = 1.00, p = .47$].

Research question 4 asked whether acculturation (AC), perceived social support (SS), or health-related quality of life (HRQL) - overall, as well as physical health (PHYS) and psychological well-being (PSYCH) - predict health-care-seeking behaviors (HCSB). Two multiple regression analyses were performed to address this research question. Social desirability scores (SD) from the Marlowe-Crowne-Social Desirability Scale were entered as a covariate in both multiple regressions to control for the influence of social desirability.

The first multiple regression model with health-care seeking behaviors (HCSB) as the criterion variable and acculturation (AC), perceived social support (SS), and overall health-related quality of life (HRQL) as the predictor variables was not significant [$F(4, 123) = 1.41, p = .24, r^2 = .05$]. This finding suggests that among the African-American women in this research, level or frequency of health-care-seeking behaviors is not significantly associated with levels of acculturation, perceived social support, or overall health-related quality of life.

The second multiple regression model with health-care seeking behaviors (HCSB) as the criterion variable and

acculturation (AC), perceived social support (SS), psychological well-being (PSYCH), and physical health (PHYS) as the predictor variables also was not significant [$F(5, 123) = 1.01, p = .39, r^2 = .04$]. This finding also suggests that among African-American women in this research, level or frequency of health-care-seeking behaviors is not significantly associated with levels of acculturation, perceived social support, psychological well-being, or physical health.

CHAPTER 5 DISCUSSION

While African Americans in general appear to experience a greater number of health problems in comparison to their White counterparts, the research on their health behaviors and/or health-care-seeking behaviors has been limited. In response to the limited research in this area, the current study was designed to examine physical, social, and psychological factors that influence African-American women's health-care-seeking behaviors.

Specifically, this study examined the relationship among acculturation, perceived social support, overall health-related quality of life, as well as physical health and psychological well-being, and health-care-seeking behaviors. In addition, this study examined whether level of acculturation, level of perceived social support, or level of overall health-related quality of life, as well as physical health and psychological well-being, predict health-care-seeking behaviors. Finally, this study assessed whether there was a significant difference in level of acculturation, level of perceived social support, or level of overall health-related quality of life, as well as

physical health and psychological well-being, in association with age and total household income.

This chapter presents a summary and interpretation of the results, the limitations of the study, the implications for practice and future research, and a conclusion.

Summary and Interpretation of the Results

Results of the preliminary Pearson correlational analysis revealed that social desirability scores (SD) were significantly correlated with three of the main variables in the study: health-care seeking behaviors (HCSB), physical health (PHYS), and psychological well-being (PSYCH). These results indicate that a response bias may have threatened the validity of the measure of the health-care-seeking behaviors variable as well as the two specific health-related quality of life variables - physical health and psychological well-being.

A significant negative correlation was found between social desirability (SD) and health-care-seeking behaviors (HCSB). The lower the HCSB score, the more likely participants felt they were to engage in health-care seeking behaviors. Thus, if a response bias or social desirability bias were indeed in effect, it would have lowered the health-care seeking behavior scores of some respondents, systematically biasing the correlations investigated. As

such, the African-American women in this study may have reported themselves as engaging in more health-care-seeking behaviors than they actually do.

Similarly, a significant negative correlation was found between social desirability (SD) and physical health (PHYS). The higher the physical health score, the more likely respondents feel that they were not inhibited in any of their physical functioning as a result of health. Since higher PHYS scores indicate fewer health-related problems, the response bias here seems to be that of African-American women reporting themselves as having more health-related problems than perhaps they actually do. This finding is surprising in that if a true social desirability bias were in effect, it would have raised the physical health scores of some respondents, systematically biasing the correlations investigated.

A significant positive correlation also was found between social desirability (SD) and psychological well-being (PSYCH). This significant correlation also suggests a response bias in responding to the psychological well-being component of the health-related quality of life measure; thus participants may have presented themselves as being more psychologically healthy than they really are.

The finding that social desirability was significantly correlated with three major variables - health-care seeking behaviors, physical health and psychological well being - is an important finding in this research, given that previous research investigating health behaviors and/or health-related quality of life and its various components failed to control for the effects of social desirability.

Specifically, previous research investigating health-related quality of life among various populations failed to control for response bias among subjects (Weinberger, Nagle, Hanlon, Samsa, Schmader, Landsman, Cowper, Cohen, & Feussner, 1994; Yamaoka, et al., 1998; Barofsky et al., 1997).

As a means for controlling for response bias in the current study, partial correlations that controlled for social desirability were used to examine hypotheses 1,2 and 3. In addition, the social desirability variable was used as a covariate in each of the univariate and multivariate analyses used to investigate research questions 1,2 and 3, as well as in the multiple regression to investigate research question 4. Even though the influence of social desirability was controlled for statistically, this is an artificial control that does not allow us to know the degree to which the results are reliable.

Findings in this research provide no support for hypothesis 1. Hypothesis one stated that a greater degree of acculturation would be significantly associated with a greater level of engagement in health-care-seeking behaviors. A partial correlation analysis performed to examine hypothesis 1 revealed no significant association between reported level of acculturation and reported level of health-care-seeking behaviors; thus this hypothesis was not supported.

The finding that acculturation and health-care-seeking behaviors were not significantly correlated in this study suggests that African-American women who are more acculturated do not necessarily engage in higher levels of health-care-seeking behaviors. This finding differs somewhat from earlier research findings that have reported that African Americans who were more acculturated did indeed show a greater level of health status and/or engagement in health-related behaviors. Specifically, Landrine and Klonoff (1996) found that African Americans (both men and women) who were more acculturated did not tend to suffer from hypertension, whereas those who were less acculturated (more traditional) did. Similarly, a related study conducted by Landrine and Klonoff (1996) showed that African Americans nonsmokers tended to be more acculturated than

their smoking counterparts, who tended to be more traditional.

The results of this study also differed from the results obtained by Maxwell, Bastani, and Warda (1998) in their study of factors affecting mammogram utilization - a health-care-seeking behavior as defined by this study. Maxwell, Bastani, and Warda found a significant positive relationship between mammography utilization and level of acculturation. Specifically, the greater the level of acculturation, the more likely the women in this study were to have had a mammogram. One difference between studies however, is the fact that Maxwell, Bastani, and Warda used Korean-American women whereas this study examined African-American women. Cultural factors may indeed be a confound when comparing results across cultures.

The current study may have failed to support earlier findings from similar research that included African Americans because the previous studies focused on measures of health status or general health behaviors and their relationship to acculturation, whereas the current study focused on specific health-care-seeking behaviors. The latter was defined as behaviors associated with seeking preventative and/or follow-up care from a health-care provider. There may or may not be a significant

relationship between health behaviors or health status and health-care-seeking behaviors as defined by this study; thus it is difficult to compare the results of research involving these different but seemingly related constructs.

Hypothesis 2 in this study stated that a greater level of perceived social support would be significantly associated with a greater level of engagement in health-care-seeking behaviors. As with hypothesis 1, results of the partial correlational analysis to test hypothesis 2 revealed no significant association between perceived social support and health-care-seeking behaviors. Thus, this hypothesis was not supported.

The finding that perceived social support and health-care-seeking behaviors were not significantly correlated in this study suggests that individuals who perceive themselves as receiving an adequate level of support from various sources in their lives do not necessarily engage in more health-care-seeking behaviors. This finding is surprising in light of the fact that previous research has found fairly significant relationships between health status/health behaviors and social support. More specifically, earlier research findings have shown that individuals who experienced higher levels of social support engaged in more positively oriented health behaviors. For instance, it has

been found that individuals who have a significant social network tend to exercise more frequently (Gottlieb & Green, 1984; Steptoe et al., 1997). In addition, Sorensen, Stoddard and Macario (1998) found that those individuals who had adequate support systems were more likely to make positive dietary changes in their lives as needed.

One reason for the lack of the predicted correlation between perceived social support and health-care-seeking behaviors is that this study used a multi-dimensional measure of social support. As such, various behaviors from various sources were presented for endorsement. In addition, satisfaction with the amount of support received from these sources was factored into the overall perceived social support score. Thus, individuals may have perceived themselves as receiving an adequate amount of social support; however, their level of satisfaction with this support may not have been strong enough to exert a positive influence on their level of engagement in health-care-seeking behaviors. Future research should focus on whether health-care-seeking behaviors in African-American women are significantly associated with both their levels of satisfaction with their social support and their overall levels of perceived social support.

Hypothesis 3 in this study stated that overall health-related quality of life, as well as physical health and psychological well-being - two components of health-related quality of life - would be significantly associated with health-care-seeking behaviors. Results of the partial correlation analysis to test hypothesis 3 revealed no significant association between overall health-related quality of life or its components (i.e., physical health and psychological well-being) and health-care-seeking behaviors. Thus, hypothesis 3 was not supported.

The finding that neither overall health-related quality of life nor its components and health-care-seeking behaviors were significantly correlated in this study suggests that individuals who experience themselves as having better health-related quality of life do not necessarily engage in more health-care-seeking behaviors. As most of the research reviewed on health-related quality of life focused on its association with health status as opposed to health behavior or health-care-seeking behaviors, it is difficult to compare the results of this study with previous research.

This study may have failed to find a significant association between health-care-seeking behaviors and health-related quality of life because it failed to assess

dimensions of health-related quality of life that are relevant for the African-American women in this research. According to Berger (1989), quality of life [as well as health-related quality of life] must be assessed specific to a particular population. While some basic quality of life measurements might be applicable to everyone in all situations, many more are relevant only to a particular group of people. Thus if the instrument used in this study failed to assess the measurements that were salient for the African-American women participants in this study, it would not adequately have captured a true measure of health-related quality of life among these women. Future research should focus on developing a measure of health-related quality of life that is geared specifically for African-American women such as the research participants in the present study.

Research question 1 investigated differences in level of acculturation in association with age and total household income. Results of the ANCOVA used to address this research question indicated that neither age nor total household income were associated with differences in level of acculturation among the African-American women in this research. These results are in keeping with the results obtained by Landrine and Klonoff (1995) in their cross-

validation of the African-American Acculturation Scale (AAAS). When Landrine and Klonoff compared the scores of a young college student sample with those of an older community sample, the scores were statistically similar for the two populations. Additionally, in their validation of the AAAS, Landrine and Klonoff (1994) found that scores on the eight subscales were not related to income, city of origin or education. As the authors stated, the purpose of the AAAS is to measure acculturation - the extent to which individuals are immersed in their culture of origin. As such, acculturation should not be related to income or other status variables. Because no significant relationships were found in this study between acculturation and status variables, it can be surmised that an accurate measure of acculturation as opposed to socioeconomic status was obtained.

The second research question investigated differences in level of perceived social support and level of health-related quality of life (as well as physical health and psychological well-being) in association with age and total household income. Results indicated that there were no significant differences in level of physical health according to age or income. These findings are inconsistent with findings from previous studies that revealed that women

who had lower incomes either experienced poorer health status or engaged in preventive health measures less frequently than those with higher incomes (Mickey, Durski, Worden, & Danigelis, 1995; Mutchler & Burr, 1991; Keith & Jones, 1990). One reason cited for such income-related differences is the fact that individuals with lower incomes do not have the resources available to them (i.e., money or health insurance) to obtain the medical care that they need. As such, many individuals without needed resources delay medical attention until their pain or symptoms are much advanced.

The finding that there was no significant relationship between income and physical health in this study could be attributed to the fact that there was a significant negative relationship between the physical health and social desirability scores. If a response bias were indeed in effect, it seems plausible that the physical health scores would have been systematically lowered across the range of income levels, thus making it difficult to detect true differences in perceived physical health between the income categories.

One reason for the lack of predicted association between psychological well-being and income could also be due to the fact that there was a significant positive

relationship between psychological well-being and social desirability. Again, if a response bias were in effect, participants would have portrayed themselves as being more psychologically healthy than they really are across all income categories. Thus it would be difficult to tell if there are indeed differences in level of psychological well-being in association with income.

The finding that there were no significant differences in physical health or psychological well-being in association with age is surprising given that physical and emotional health is often seen as declining with age. A possible reason for the lack of association in this study is that the majority of the participants ($n = 90$) were age 50 and below. Future research should focus on obtaining a more representative sample across all age categories.

Research question 3 asked whether there was a significant difference in level of health-care-seeking behavior in association with age and total household income. Results indicated that age nor total household income was associated with health-care-seeking behaviors. This lack of association was not expected due to the fact that the literature, as mentioned before, reports income as being one of the determinants of both health status and health-care

services utilization (Mickey, et al., 1995; Mutchler & Burr, 1991; Keith & Jones, 1990).

One possible explanation for not finding significant differences in level of health-care-seeking behaviors in association with age and income is that health-care-seeking behaviors was found to be significantly correlated with social desirability. As such, this would systematically bias the health-care-seeking behavior scores of African-American women in this study. In other words, participants may have presented themselves as engaging in more health-care-seeking behaviors than they actually do, thus making it difficult to distinguish differences across the age and income spectrum.

Research question 4 asked whether level of acculturation, level of perceived social support or level of health-related quality of life predict health-care-seeking behavior. Results indicated that neither acculturation, perceived social support nor health-related quality of life predicted health-care-seeking behaviors. This finding suggests that health-care-seeking behaviors, for those who participated in this study, are likely due to factors not investigated in this study. Further research is needed to ascertain factors that might be predictive of African-American women's health-care-seeking behaviors in general.

Additional results from the study indicated that the African-American women who participated in this study experienced higher levels of psychological well-being in association with higher levels of perceived social support. In addition, the more acculturated these participants were, the greater their levels of psychological well-being. These findings suggest that for the participants in this study, having a functional social support system in their lives is important to their overall level of psychological well-being. Further research is needed to determine the role acculturation plays in the psychological well-being of African-American women.

Limitations of the Study

There are several limitations of this study that warrant discussion. First, only self-report measures were used in the actual data collection. While self-reports are a primary source of data in both psychological and social sciences (Schwarz, 1999), participants may have under- or over-reported the physical, psychological or social variables examined in this study due to their tendency to respond to questions in a socially desirable manner. This tendency may have been true in this study as results indicated that there were indeed significant correlations between social desirability and three major variables in

this study (health-care-seeking behaviors, physical health, and psychological well-being). In an effort to address this potential limitation, social desirability was controlled for in the present study.

In addition, self-reports can be seen as a fallible source of data as even minor changes in how the questions are worded or formatted can lead to major changes in the obtained results (Schwarz, 1999). As referenced in Schwarz, when a group of participants were asked how successful they had been in life, results varied significantly based on the rating scale used. Specifically, when a scale of -5 to 5 was used, 34% of the respondents reported high success. However, when the rating scale was changed to 0 to 10, only 13% reported high success. According to Schwarz, factors involved in self-report research that can significantly influence results are those such as making sense of the questions asked and types of response alternatives. Even so, given the paucity of research in the area of African-American women's health, self-report questionnaire research is indeed a first step.

Another major limitation of this study is the small sample size ($N = 124$). With a larger sample, perhaps statistical results that approached significance would have actually been significant. This brings up the larger issue

of how researchers might successfully recruit African Americans as participants in various research efforts. Extensive efforts were expended to recruit participants for this study; however, these efforts resulted in a limited number of participants. As part of the recruitment efforts in the present study, a monetary compensation (\$10) was used as a participation incentive. While \$10 may have been a strong incentive for some individuals, others may have needed a clearer understanding of and acknowledgment of the importance of health-related research to be inspired to participate in this research.

Another possible limitation in this study is the appropriateness of the inventories for African Americans. While the African-American Acculturation Scale was designed specifically for African Americans, the other inventories were universal in nature. Often there is an assumed universality to research inventories at the expense of their cultural relevance. As stated by Ibrahim and Arrendondo, it is imperative that cultural issues be taken into account when conducting research (1986). This attention to culture would include the use of appropriate instrumentation.

Finally, limitations in this study might have occurred as the result of the use of the Health-Care-Seeking Behavior Questionnaire (HCSBQ) constructed by the researcher. As

there was no test-retest data or validity data on the instrument, it might not have captured the true meaning of health-care-seeking behaviors that the researcher intended. Future research with this measure would need to assess the reliability as well as the validity of this measurement.

Implications for Practice and Future Research

Limitations did indeed exist in this study; yet, these findings have implications for counseling psychologists. Because many of the findings were inconsistent with related previous research involving both African Americans in general and African-American women in particular, a necessary first step would be to see if the findings in this research were a result of issues expounded on in the limitations section. If this study could be replicated with a larger sample size and with a more culturally sensitive design (e.g., use of culturally specific instruments or measures), findings might indeed support previous literature showing that acculturation, perceived social support and health-related quality of life are associated with some form of positive health behavior.

According to Casas and Thompson (1991), research that takes into account the values and diversity of worldviews held by other cultures would challenge the researcher to work within the community itself in order to solve real-

world problems. In addition, it would promote an active role of leaders within minority communities in order to identify those research projects that are deemed important by the community. As such, future research examining the relationship among acculturation, perceived social support, health-related quality of life and health-care-seeking behaviors might focus on the use of trained community leaders within the African-American community to interview African-American women about their health-care-seeking behaviors.

Conclusion

The current study examined acculturation, perceived social support and overall health-related quality of life (as well as physical health and psychological well-being) as factors in health-care-seeking behaviors among African-American women. Results of this research clearly show that there is indeed a need for more in-depth research regarding African-American women and their health-care-seeking behaviors. This need is reflected in the fact that the factors in the health-care-seeking behaviors of these African-American women remain unclear. The examined factors together accounted for only 5% of the variance in health-care-seeking behaviors as measured in the current study.

Given that African-American women have higher health risks than White women, future research to further investigate the factors in health-care-seeking behavior of African-American women is clearly needed. This future research will benefit from efforts to promote honest rather than socially appropriate responses to assessments used in such research. In addition, this research will be enhanced by the use of culturally sensitive assessments of the investigated predictors of health-care-seeking behaviors.

APPENDIX A
INFORMED CONSENT FORM

You are being asked to volunteer as a participant in a research study. This form is designed to inform you about the nature of the study. The purpose of this study is to help psychologists learn more about how African-American women cope with health problems.

Participants in this study will be asked to complete a set of questionnaires. The questionnaires can be completed in approximately one hour, but you will be allowed as much time as you need. You will be asked not to put your names on the questionnaires so that your right to confidentiality is protected. Instead, all questionnaires in each packet will have the same code on it for matching purposes. Completed questionnaires will be stored in a locked filing cabinet in the psychology building at the University of Florida.

As immediate compensation for your participation in this study, you will receive \$10.00 cash.

Individual results from this study will not be available; however, group results will be made available via mail upon your written request. A "Request for Results" card will be provided for your signature. There are no risks or discomforts anticipated for participants in this study. You may benefit from your participation in this study by learning more about your own health and your health practices. If you wish to discuss any discomforts you may experience, you may call Ms. Alaycia D. Reid, Principal Investigator, at (614) 292-5766, or Dr. Carolyn M. Tucker at (352) 392-0601, ext. 260. Please read the statement below and sign the form.

I have been fully informed of the procedure for the above-described study and understand its possible benefits and risks. I also understand that I will receive \$10.00 as compensation for my participation in this study. I understand that I am free to discontinue my participation in

this study at any time. I agree to participate in the procedure and have received a copy of this description.

Signature of Participant

Date

Signature of Principal Investigator,
Alaycia DeNeen Reid, M.S.
Box 119
Psychology Building
392-0601

Date

APPENDIX B
DEMOGRAPHIC QUESTIONNAIRE

Please complete the following information by filling in the blank or checking the appropriate category.

1. Age:

_____	21 - 30 Years Old
_____	31 - 40 Years Old
_____	41 - 50 Years Old
_____	51 - 60 Years Old
_____	61 Years Old or Over

2. Paid Employment Status:

_____	Full Time
_____	Part Time
_____	None

3. Relationship Status:

_____	Single
_____	Partnered
_____	Married
_____	Legally Separated
_____	Legally Divorced
_____	Widowed

4. Current Total Household Income:

_____	Less than \$15,000
_____	\$15,001 - \$30,000
_____	\$30,001 - \$45,000
_____	more than \$45,000

APPENDIX C
AFRICAN-AMERICAN ACCULTURATION SCALE

Instructions: Please tell us how much you personally agree or disagree with the beliefs and attitudes listed below by circling a number from 1 to 7. There is no right or wrong answer. We want your honest opinion.

- | I Totally Disagree
Not True at All | I Sort of Agree
Sort of True | I Strongly Agree
Absolutely True |
|--|---------------------------------|-------------------------------------|
| 1 | 2 | 3 |
| 4 | 5 | 6 |
| 7 | | |
| 1. One or more of my relatives knows how to do hair. | | |
| 1 | 2 | 3 |
| 4 | 5 | 6 |
| 7 | | |
| 2. When I was young, my parent(s) sent me to stay with a relative (aunt, uncle, grandmother) for a few days or weeks, and then I went back home again. | | |
| 1 | 2 | 3 |
| 4 | 5 | 6 |
| 7 | | |
| 3. When I was young, I shared a bed at night with my sister, brother, or some other relative. | | |
| 1 | 2 | 3 |
| 4 | 5 | 6 |
| 7 | | |
| 4. When I was young, my cousin, aunt, grandmother, or other relative lived with me and my family for a while. | | |
| 1 | 2 | 3 |
| 4 | 5 | 6 |
| 7 | | |
| 5. When I was young, my mother or grandmother was the "real" head of the family. | | |
| 1 | 2 | 3 |
| 4 | 5 | 6 |
| 7 | | |
| 6. When I was young, I took a bath with my sister, brother, or some other relative. | | |
| 1 | 2 | 3 |
| 4 | 5 | 6 |
| 7 | | |
| 7. Old people are wise. | | |
| 1 | 2 | 3 |
| 4 | 5 | 6 |
| 7 | | |

8. I often lend money or give other types of support to members of my family.
1 2 3 4 5 6 7
9. It's better to try to move your whole family ahead in this world than it is to be out for only yourself.
1 2 3 4 5 6 7
10. A child should not be allowed to call a grown woman by her first name, "Alice." The child should be taught to call her "Miss Alice."
1 2 3 4 5 6 7
11. It's best for infants to sleep with their mothers.
1 2 3 4 5 6 7
12. Some members of my family play the numbers.
1 2 3 4 5 6 7
13. I know how to play bid whist.
1 2 3 4 5 6 7
14. Most of my friends are Black.
1 2 3 4 5 6 7
15. I feel more comfortable around Blacks than around Whites.
1 2 3 4 5 6 7
16. I listen to Black radio stations.
1 2 3 4 5 6 7
17. I try to watch all the Black shows on TV.
1 2 3 4 5 6 7
18. I read (or used to read) *Essence* or *Ebony* magazine.
1 2 3 4 5 6 7
19. Most of the music I listen to is by Black artists.
1 2 3 4 5 6 7
20. I like Black music more than White music.
1 2 3 4 5 6 7
21. The person I admire most is Black.
1 2 3 4 5 6 7

22. When I pass a Black person (a stranger) on the street,
I always say hello or nod at him or her.
1 2 3 4 5 6 7
23. I read (or used to read) Jet magazine.
1 2 3 4 5 6 7
24. I usually add salt to my food to make it taste better.
1 2 3 4 5 6 7
25. I know how long you are supposed to cook collard
greens.
1 2 3 4 5 6 7
26. I save grease from cooking to use it again.
1 2 3 4 5 6 7
27. I know how to cook chit'lins.
1 2 3 4 5 6 7
28. I eat grits once in a while.
1 2 3 4 5 6 7
29. I eat a lot of fried foods.
1 2 3 4 5 6 7
30. Sometimes I eat collard greens.
1 2 3 4 5 6 7
31. Sometimes I cook ham hocks.
1 2 3 4 5 6 7
32. People say I eat too much salt.
1 2 3 4 5 6 7
33. I eat chit'lins once in a while.
1 2 3 4 5 6 7
34. Most tests (like the SATs and tests to get a job) are
set up to make sure Blacks don't get high scores on
them.
1 2 3 4 5 6 7
35. Deep in their hearts, most White people are racists.
1 2 3 4 5 6 7

36. IQ tests were set up purposefully to discriminate against Black people.
1 2 3 4 5 6 7
37. Whites don't understand Blacks.
1 2 3 4 5 6 7
38. Some members of my family hate or distrust White people.
1 2 3 4 5 6 7
39. I don't trust most White people.
1 2 3 4 5 6 7
40. Most Whites are afraid of Blacks.
1 2 3 4 5 6 7
41. There are many types of blood, such as "high," "low," "thin," and "bad" blood.
1 2 3 4 5 6 7
42. I was taught you shouldn't take a bath and then go outside.
1 2 3 4 5 6 7
43. Illness can be classified as natural types and unnatural types.
1 2 3 4 5 6 7
44. I believe that some people know how to use voodoo.
1 2 3 4 5 6 7
45. Some people in my family use Epsom salts.
1 2 3 4 5 6 7
46. I know what "falling out" means.
1 2 3 4 5 6 7
47. Some old Black women/ladies know how to cure diseases.
1 2 3 4 5 6 7
48. Some older Black women know a lot about pregnancy and childbirth.
1 2 3 4 5 6 7
49. Prayer can cure disease.
1 2 3 4 5 6 7

50. I have seen people "fall out."
1 2 3 4 5 6 7
51. If doctors can't cure you, you should try going to a
root doctor or to your minister.
1 2 3 4 5 6 7
52. I have "fallen out."
1 2 3 4 5 6 7
53. I believe in heaven and hell.
1 2 3 4 5 6 7
54. I like gospel music.
1 2 3 4 5 6 7
55. The Church is the heart of the Black community.
1 2 3 4 5 6 7
56. I am currently a member of a Black church.
1 2 3 4 5 6 7
57. I have seen people "get the spirit" or speak in
tongues.
1 2 3 4 5 6 7
58. I believe in the Holy Ghost.
1 2 3 4 5 6 7
59. I went to a mostly Black elementary school.
1 2 3 4 5 6 7
60. When I was young, I was a member of a Black church.
1 2 3 4 5 6 7
61. I grew up in a mostly Black neighborhood.
1 2 3 4 5 6 7
62. The biggest insult is an insult to your mother.
1 2 3 4 5 6 7
63. I went to (or go to) a mostly Black high school.
1 2 3 4 5 6 7
64. Dancing was an important part of my childhood.
1 2 3 4 5 6 7

65. I used to sing in the church choir.
1 2 3 4 5 6 7
66. When I was young, I used to play tonk.
1 2 3 4 5 6 7
67. When I was young, I used to double-dutch.
1 2 3 4 5 6 7
68. I currently live in a mostly Black neighborhood.
1 2 3 4 5 6 7
69. I used to like to watch Soul Train.
1 2 3 4 5 6 7
70. What goes around, comes around.
1 2 3 4 5 6 7
71. There's some truth to many old superstitions.
1 2 3 4 5 6 7
72. I avoid splitting a pole.
1 2 3 4 5 6 7
73. When the palm of your hand itches, you'll receive some money.
1 2 3 4 5 6 7
74. I eat black-eyed peas on New Year's Eve.
1 2 3 4 5 6 7

APPENDIX D
MULTIDIMENSIONAL SUPPORT SCALE

I am going to ask you some questions about the kind of help and support you have available to you in coping with your life at present. The questions refer to three different groups of people who might have been providing support to you IN THE LAST MONTH. For each question, please circle the number or phrase that corresponds with your answer.

First, think of your family and close friends - especially the 2-3 who are most important to you.

1 = Never; 2 = Sometimes; 3 = Often; 4 = Usually/Always

1a. How often did they really listen to you when you talked about your concerns or problems?

1 2 3 4

1b. And you would have liked them to do this:

more often/ less often/ it was just about right

2a. How often did you feel that they were really trying to understand your problems?

1 2 3 4

2b. And you would have liked them to do this:

more often/ less often/ it was just about right

3a. How often did they try to take your mind off your problems by telling jokes or chattering about other things?

1 2 3 4

3b. And you would have liked them to do this:

more often/ less often/ it was just about right

4a. How often did they really make you feel loved?

1 2 3 4

4b. And you would have liked them to do this:

more often/ less often/ it was just about right

5a. How often did they help you in practical ways, like doing things for you or lending you money?

1 2 3 4

5b. And you would have liked them to do this:

more often/ less often/ it was just about right

6a. How often did they answer your questions or give you advice about how to solve your problems?

1 2 3 4

6b. And you would have liked them to do this:

more often/ less often/ it was just about right

7a. How often could you use them as examples of how to deal with your problems?

1 2 3 4

7b. And you would have liked them to do this:

more often/ less often/ it was just about right

APPENDIX E
RAND 36-ITEM HEALTH SURVEY (VERSION 1.0)

Directions: Please respond to the following questions or statements by circling the response that best fits how you feel.

1. In general, would you say your health is:
 - 1 Excellent
 - 2 Very Good
 - 3 Good
 - 4 Fair
 - 5 Poor

2. Compared to one year ago, how would you rate your health in general now?
 - 1 Much Better now than one year ago
 - 2 Somewhat better now than one year ago
 - 3 About the same as one year ago
 - 4 Somewhat worse now than one year ago
 - 5 Much worse now than one year ago

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

3. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports
 - 1 Yes, Limited a lot
 - 2 Yes, Limited a little
 - 3 No, Not limited at all

4. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf
 - 1 Yes, Limited a lot
 - 2 Yes, Limited a little
 - 3 No, Not limited at all

5. *Lifting or carrying groceries*
- 1 Yes, Limited a lot
 - 2 Yes, Limited a little
 - 3 No, Not limited at all
6. *Climbing several flights of stairs*
- 1 Yes, Limited a lot
 - 2 Yes, Limited a little
 - 3 No, Not limited at all
7. *Climbing one flight of stairs*
- 1 Yes, Limited a lot
 - 2 Yes, Limited a little
 - 3 No, Not limited at all
8. *Bending, kneeling, or stooping*
- 1 Yes, Limited a lot
 - 2 Yes, Limited a little
 - 3 No, Not limited at all
9. *Walking more than a mile*
- 1 Yes, Limited a lot
 - 2 Yes, Limited a little
 - 3 No, Not limited at all
10. *Walking several blocks*
- 1 Yes, Limited a lot
 - 2 Yes, Limited a little
 - 3 No, Not limited at all
11. *Walking one block*
- 1 Yes, Limited a lot
 - 2 Yes, Limited a little
 - 3 No, Not limited at all
12. *Bathing or dressing yourself*
- 1 Yes, Limited a lot
 - 2 Yes, Limited a little
 - 3 No, Not limited at all

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

13. Cut down on the amount of time you spent on work or other activities

1 Yes
2 No

14. Accomplished less than you would like

1 Yes
2 No

15. Were limited in the kind of work or other activities

1 Yes
2 No

16. Had difficulty performing the work or other activities (for example, it took extra effort)

1 Yes
2 No

During the past 4 weeks, have you had any of the following problems with your work or other regular activities as a result of any emotional problems (such as feeling depressed or anxious)?

17. Cut down on the amount of time you spent on work or other activities

1 Yes
2 No

18. Accomplished less than you would like

1 Yes
2 No

19. Didn't do work or other activities as carefully as usual

1 Yes
2 No

20. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

- 1 Not at all
- 2 Slightly
- 3 Moderately
- 4 Quite a bit
- 5 Extremely

21. How much bodily pain have you had during the past 4 weeks?

- 1 None
- 2 Very mild
- 3 Mild
- 4 Moderate
- 5 Severe
- 6 Very severe

22. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

- 1 Not at all
- 2 A little bit
- 3 Moderately
- 4 Quite a bit
- 5 Extremely

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks

23. Did you feel full of pep?

- 1 All of the time
- 2 Most of the time
- 3 A good bit of the time
- 4 Some of the time
- 5 A little of the time
- 6 None of the time

24. Have you been a very nervous person?

- 1 All of the time
- 2 Most of the time
- 3 A good bit of the time
- 4 Some of the time
- 5 A little of the time
- 6 None of the time

25. Have you felt so down in the dumps that nothing could cheer you up?

- 1 All of the time
- 2 Most of the time
- 3 A good bit of the time
- 4 Some of the time
- 5 A little of the time
- 6 None of the time

26. Have you felt calm and peaceful?

- 1 All of the time
- 2 Most of the time
- 3 A good bit of the time
- 4 Some of the time
- 5 A little of the time
- 6 None of the time

27. Did you have a lot of energy?

- 1 All of the time
- 2 Most of the time
- 3 A good bit of the time
- 4 Some of the time
- 5 A little of the time
- 6 None of the time

28. Have you felt downhearted and blue?

- 1 All of the time
- 2 Most of the time
- 3 A good bit of the time
- 4 Some of the time
- 5 A little of the time
- 6 None of the time

29. Did you feel worn out?

- 1 All of the time
- 2 Most of the time
- 3 A good bit of the time
- 4 Some of the time
- 5 A little of the time
- 6 None of the time

30. Have you been a happy person?

- 1 All of the time
- 2 Most of the time
- 3 A good bit of the time
- 4 Some of the time
- 5 A little of the time
- 6 None of the time

31. Did you feel tired?

- 1 All of the time
- 2 Most of the time
- 3 A good bit of the time
- 4 Some of the time
- 5 A little of the time
- 6 None of the time

32. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

- 1 All of the time
- 2 Most of the time
- 3 Some of the time
- 4 A little of the time
- 5 None of the time

How TRUE or FALSE is each of the following statements for you?

33. I seem to get sick a little easier than other people

- 1 Definitely true
- 2 Mostly true
- 3 Don't know
- 4 Mostly false
- 5 Definitely false

34. I am as healthy as anybody I know

- 1 Definitely true
- 2 Mostly true
- 3 Don't know
- 4 Mostly false
- 5 Definitely false

35. I expect my health to get worse

- 1 Definitely true
- 2 Mostly true
- 3 Don't know
- 4 Mostly false
- 5 Definitely false

36. My health is excellent

- 1 Definitely true
- 2 Mostly true
- 3 Don't know
- 4 Mostly false
- 5 Definitely false

Note: The RAND 36-ITEM HEALTH SURVEY 1.0 was reprinted with permission from the publisher. The RAND 36-ITEM HEALTH SURVEY was developed in conjunction with the Medical Outcome Study. Copyright 1986, 1992 by RAND.

APPENDIX F
Health-care-seeking BEHAVIOR QUESTIONNAIRE

Instructions: Please respond to the following questions by circling a number from 1 to 5 (1,2,3,4, or 5) that best fits your answer.

1. How likely are you to visit your doctor or other health-care provider for a yearly physical check-up?
1-----2-----3-----4-----5
Very Likely Not Likely at All
2. How likely are you visit your doctor or other health-care provider for a yearly gynecological exam?
1-----2-----3-----4-----5
Very Likely Not Likely at All
3. How likely are you to go to the doctor or other health-care provider when you start to feel ill?
1-----2-----3-----4-----5
Very Likely Not Likely at All
4. How likely are you to go to the doctor or other health-care provider when you feel very ill?
1-----2-----3-----4-----5
Very Likely Not Likely at All
5. How likely are you to have a mammogram as often as recommended by your doctor or other health-care provider?
1-----2-----3-----4-----5
Very Likely Not Likely at All
6. How likely are you to have access to a medical doctor or other medical facility if needed?
1-----2-----3-----4-----5
Very Likely Not Likely at All

7. How likely are you to have medical insurance or other means for paying for medical care?

1-----2-----3-----4-----5
Very Likely Not Likely at All

8. How likely are you to maintain follow-up visits with a doctor or other health-care provider once under their care?

1-----2-----3-----4-----5
Very Likely Not Likely at All

9. How likely are you to get a prescription filled?

1-----2-----3-----4-----5
Very Likely Not Likely at All

10. How likely are you to take all the medicine your doctor or other health-care provider prescribes?

1-----2-----3-----4-----5
Very Likely Not Likely at All

APPENDIX G
MARLOWE-CROWNE SOCIAL DESIRABILITY SCALE -(20)

Directions: Read or Listen to the following statements and indicate whether you consider the statement to be true or false.

- | | | | |
|---|----|-----|--|
| T | F | 1. | I never hesitate to go out of my way to help someone in trouble. |
| T | F | 2. | I have never intensely disliked someone. |
| T | F. | 3. | I sometimes feel resentful when I don't get my way. |
| T | F | 4. | I like to gossip at times. |
| T | F | 5. | There have been times when I felt like rebelling against people in authority even though I knew they were right. |
| T | F | 6. | I can remember "playing sick" to get out of something. |
| T | F | 7. | There have been occasions when I took advantage of someone. |
| T | F | 8. | I am always willing to admit it when I make a mistake. |
| T | F | 9. | I always try to practice what I preach. |
| T | F | 10. | I sometimes try to get even rather than forgive and forget. |
| T | F | 11. | When I don't know something, I don't at all mind admitting it. |
| T | F | 12. | I am always courteous, even to people who are disagreeable. |

- T F 13. At times, I have really insisted on having things my own way.
- T F 14. There have been occasions when I felt like smashing things.
- T F 15. I would never think of letting someone else be punished for my wrong-doings.
- T F 16. I never resent being asked to return a favor.
- T F 17. I have never been irked when people expressed ideas very different from my own.
- T F 18. There have been times when I was quite jealous of the good fortune of others.
- T F 19. I am sometimes irritated by people who ask favors of me.
- T F 20. I have never deliberately said something that hurt someone's feelings.

APPENDIX H
DEBRIEFING FORM

Thank you for your participation in this study. Your responses to the questionnaires will be kept completely confidential; your questionnaires will be matched together by code number only. Furthermore, the questionnaires that you completed will be kept in a locked file drawer to which only the Principal Investigator and two research assistants will have access.

The purpose of this study was to examine acculturation, perceived social support, and overall health-related quality of life (as well as psychological well-being and physical health) on health-care-seeking behaviors among African-American women.

Thank you again for your participation in this study. If you have any questions at all about the study, please feel free to contact the Principal Investigator, Alaycia Reid, at (614)-292-5766 or Dr. Carolyn M. Tucker at (352)-392-0601, ext. 260.

Please initial and date your initials below:

Initials

Date

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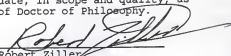
BIOGRAPHICAL SKETCH

Alaycia DeNeen Reid was born in Waycross, Georgia. She obtained her B.S. degree in psychology from the University of Georgia in March 1987. Upon graduation, she obtained a position at an adolescent mental health clinic where she served as a human service provider for two years.

Alaycia entered graduate school in the fall of 1990 at Georgia State University. There she obtained a M.S. degree in community counseling in June 1992. Concurrently, she obtained a diploma in Christian counseling from the Psychological Studies Institute in Atlanta, Georgia.

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I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.



Robert Ziller
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This dissertation was submitted to the Graduate Faculty of the Department of Psychology in the College of Liberal Arts and Sciences and to the Graduate School and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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